Supreme Court, U.S.
FILED

01-891 DEC 18 2001

OFFICE OF THE CLERK

No. _____

In The

Supreme Court of the United States

JOHN MANNING REGAN, for himself and for all others similarly situated,

Petitioner,

v.

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE and METROPOLITAN LIFE INSURANCE CO., and UNITED HEALTHCARE CORPORATION,

Respondents.

On Petition for a Writ of Certiorari to the Supreme Court of the State of New York, Appellate Division, Fourth Judicial Department

PETITION FOR WRIT OF CERTIORARI AND APPENDIX

James A. Robinson, Esq.
Counsel of Record
REGAN & REGAN, P.C.
19 Main Street West, Suite 800
Rochester, New York 14614
(585) 546-8880

Counsel for Petitioner

11 Centre Park
Rochester, New York 14614
(716) 232-6920

(4567)
THE DAILY RECORD

107 Delaware Avenue — Suite 81
Buffalo, New York 14202
(716) 847-2984

133 pp

RULE 14

(a) Questions Presented

I.

Title 42 §1395 p. of the United States Code subparagraph (d), establishes an initial enrollment period for the Medicare program for individuals becoming eligible for Medicare benefits when they attain age 65. Its duration is seven months.

Title 42 §1395 q. of the United States Code, subparagraph (a), establishes the time when coverage under Medicare B commences in relation to the time enrollment occurs during the initial enrollment period. The commencement of coverage under Medicare B can vary as much as six months depending on the month when enrollment occurs during the initial enrollment period.

These federal statutes define and control the meaning of Medicare enrollment "when first eligible" at age 65.

Question:

Can a State establish a group health insurance plan which mandates participants' enrollment in Medicare B "when eligible for primary Medicare coverage", and which then *assumes*, without any additional notice, or informed consent from such participants, that Medicare B coverage has commenced for them as of the very earliest possible date under 42 U.S.C. 1395 q. in order to terminate its health insurance primary medical coverage at that earliest possible time, or, do these federal statutes:

(1) Under the Supremacy Clause of the U. S. Constitution, bar any state authorized health plan's redefinition or modification of their terms regarding the length of the initial enrollment period or its assumption of commencement of coverage under Medicare B at the earliest time when those plans use only the phrase "when eligible for primary Medicare coverage" to advise their participants of the duty to enroll?

OR

(2) Require a State group health insurance plan to extract a

specific waiver, consciously and voluntarily consented to, from each such participant, acknowledging that the State's group health insurance plan has both shortened the length of the initial enrollment period for Medicare B and has insisted upon the commencement of Medicare B coverage as of the earliest possible date under §1395 q, in order to make the plan's medical insurance coverage secondary to Medicare B at that earliest time?

N.B. The Courts below have ruled that these federal statutes neither bar the insurer's *assumption* of its participants' commencement of Medicare B coverage at the earliest possible date, nor require any specific notice or waiver of their terms from group health insurance plan participants at the time when they first become eligible for Medicare B coverage at age 65.

SUBSIDIARY QUESTION: Whether the process of incorporating Medicare B as the primary payor under a State Employees Group Health Insurance Plan is controlled by Federal or by State laws and regulations, or by both, where not inconsistent? Specifically, in this case, whether the scope of the notice advising participants of the way Medicare B is integrated into the Health Plan is a substantial federal question?

II.

Subchapter XX of Title 42 of the United States Code, §§ 300 bb-1 through 300 bb-8 establishes requirements for Group Health Insurance Plans for State and local government employees. Its essential feature is to mandate that "as to each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event, he then(becomes) entitled, under the Plan, to elect, within the election period, *continuation coverage* under the plan." See 42 U.S.C. §300 bb-1, subparagraph (a).

42 U.S.C. 300 bb-2 subparagraph (2)(A) provides for a maximum required period of time of 18 months for "*continuation coverage.*" The statute, however, does not forbid

voluntary periods of time, beyond 18 months, for *continuation coverage*.

42 U.S.C. 300-bb-2, subparagraph (2)(D) authorizes a State health plan to end *continuation coverage* on the date on which the beneficiary first becomes: "(ii) entitled to benefits under Title XVIII of the Social Security Acts (42 U.S.C., §1395 et seq.)"

42 U.S.C. 300 bb-3 defines "qualifying event." Subparagraph (2) of that section states that the covered employee's termination of employment is a qualifying event.

First Question: Do the terms of Title 42 U.S.C. 300 bb-2 subparagraph (2)(A) imply that federally mandated continuation coverage automatically ends 18 months after the qualifying event, and the federal statute thereafter becomes inapplicable for all purposes, or may a State group health insurance plan extend continuation coverage beyond the 18 month period, thereby waiving its right to terminate continuation coverage at that time, in which case, do the subsequent statutory provisions in § 300 bb-2, subparagraph (2) continue in force? Cf. Oakley v. City of Longmont, 890 F.2d 1128 (10th Cir. 1989) at p. 1132, which holds that termination after 18 months is *automatic*.

Second Question: In the face of such federal statutory provisions, can New York State authorize the termination of primary medical insurance *continuation coverage* "as of the first possible Medicare B effective date a NYSHIP (New York State Health Insurance Plan) participant can have under the federal rules" regardless of whether the participant is entitled to Medicare benefits on that date, and based solely on his eligibility for Medicare B at that time?

Or, must such continuation coverage remain in force until, as §300 bb-2, subparagraph (2)(D)(ii) provides, the participant has become "entitled to benefits" under the Medicare Acts?

Third Question: Moreover, can a State authorized group health

insurance plan create a six month gap in primary medical insurance *continuation coverage* as a consequence of its statutes, assumptions, and administrative regulations - a gap which petitioner herein has experienced to his financial damage, or does the plain Congressional intent of subchapter XX forbid creating such a gap in coverage? Cf Teweleit v. Hartford Ins. Co. 43 F.3rd 1005 (5th Cir.1995) at p. 1008-1009, which holds that the purpose of COBRA coverage is to "eliminate gaps in insurance coverage that could accompany changes in, or loss of, employment."

III.

Title 42 U.S.C. §300 bb-6 establishes the notice requirements a state group health insurance plan must provide to each covered employee at the time of commencement of coverage under the plan. The notice must advise the employee of his "rights under this subsection (i.e.. subchapter XX)."

Question: Did the notices in this Record comply with the provisions of 42 U.S.C. §300 bb-6? Specifically, did the notices advise that termination of continuation coverage after 18 months was automatic? Did the notices advise that termination of primary medical coverage would occur at the earliest possible date under the federal rules, based on an assumption of enrollment at that time of eligibility?

IV.

Question: Does the Complaint Petitioner filed herein on his own behalf, and on behalf of a class of approximately 250 other participants in NYSHIP, state a cause of action under the federal statutes it recites upon which the relief the Complaint demands ought to be granted? See 42 U.S.C. §300 bb-7. And can petitioner bring a class action to enforce such a cause of action on behalf of a group?

V.

In view of the findings of the trial court that "(petitioner) never

lost his insurance coverage [illegible] rather it became secondary to Medicare B when he reached [illegible]e 65" (See Appendix at p. A-8); which findings the Appellate Division has now affirmed, and in view of Rule 73.2 of the New York Department of Civil Service, have the Courts below, as a matter of law, determined that NYSHIP has violated the terms of the Medicare as Secondary Payor Act. 42U.S.C. 1395y, subparagraph (b)?

(b) The Parties

The parties herein are as listed in the caption of the Petition.

The affiliates of Metropolitan Life Insurance Co. and United Healthcare, Inc. are as set forth in the appendix attached hereto at pp. A-95-A-105. The Respondents have provided this information in papers filed in the Court below. Petitioner has no first-hand knowledge of their accuracy.

(c) Table of Contents

	Page No.
Questions Presented	i-v
The Parties	v
Citations to the Orders Entered herein	viii
Statement as to the Jurisdiction of the Supreme Court	ix
Citation to the federal statutes involved in the Case	viii
Statement of the Case	1
Argument for Issuance of the Writ of Certiorari	6
Appendix	
Opinion of the Court of first instance, and its Judgment	A-1- A-8
Order of Appellate Division affirming Judgment	A-9-A-10
Order of the Court of Appeals denying leave to Appeal	A-11-A-12
Petitioner's Complaint	A-13-A-48
Reply Affidavit of Christine Williams dated 6/18/98	A-49-A-74
Texts of the Federal and State Statutes and State Regulations involved in this case	A-75-A-94
42 U.S.C. 1395 p	A-75-A-76
42 U.S.C. 1395 q	A76-A-77
42 U.S.C. 1395 y	A-77-A-78
26 U.S.C. 5000	A-79
42 U.S.C. 1395 y	A-79-A-92

42 U.S.C. 300 bb-1 - 300 bb8	A-92-A-93
N.Y. Civil Service Law §163	A-93
N.Y. Civil Service Law §165, subpar (1)	A-93-A-94
N.Y. Civil Service Regulation §73.2(a)(3)	A-93-A-94
Subsidiaries of the Respondents, Exhibit A and B	A-95-A-105

Table of Authorities Cited

----------o----------

Cases	Page No.
Larsen v. Senate of Commonwealth of Pa. 154 F.3rd 82 (3rd Cir. 1998)	10
Layaou v.Xerox Corp., 238 F.3rd 205 (2nd Cir 2001)	13
Oakley v.City of Longmont, 890 F.2d 1128 (10th Cir 1989)	iii, 12, 13
Santana v. DeLuxe Corp., 12 F. Supp 2nd 162 (U.S.D.C. Mass. 1998)	13
Teweleit v. Hartford Ins. Co., 43 F.3rd 1005 (5th Cir. 1995)	iv
Constitutional Provisions	i, x, xi
Statutes	(A-75-A-94)
42 U.S.C. 1395 p	i, 1, 6, 7, 14
42 U.S.C. 1395 q	i, ii, 1, 4, 6, 7, 13, 14
42 U.S.C. 1395 y	v, 9, 10
26 U.S.C. 5000	9
42 U.S.C. 300 bb-1-300 bb-8	ii, iii, iv, 1, 2, 3,5, 7,8, 9, 10, 11, 12, 13
N.Y. Civil Service Law § 163	3
N.Y. Civil Service Law § 165	3, 10, 12
N.Y. Civil Service Regulation §73.2	v, 3, 8,10

(d) Citations to the Reports of the State of New York of the Opinions and Orders Entered in this Case by the Courts Below

Regan v. Department of Civil Service, etal.
Citation: 2001 W.L. 633624
2001 N.Y. Slip 5112
284 A.D.2d 950 (4th Dept. 2001)
(New York Appellate Division Reports Second Series)
Lower Court opinion unreported.

(e) Statement as to the Jurisdiction of the Supreme Court of the United States

In accordance with subparagraph 1. (e) of Rule 14, petitioner supplies the following facts:

The Order sought to be reviewed was entered in this Case on June 8th, 2001 by the Clerk of the Appellate Division of the Supreme Court of the State of New York, Fourth Judicial Department.

The Order of the Appellate Division was subject to discretionary review by the Court of Appeals of the State of New York, the Court of last resort in New York.

Petitioner moved for leave to Appeal to the Court of Appeals on July 3rd, 2001.

The Court of Appeals entered an Order denying the motion to grant leave to appeal on September 20th, 2001.

No motion for rehearing has been made.

The statutory provision which confers jurisdiction on this Court to review the order of the Court below by writ of Certiorari is Title 28 United States Code §1257 (a).

(f) THE STATUTORY & CONSTITITIONAL PROVISIONS INVOLVED IN THE CASE

N.B. In accordance with Rule 14, 1(f), and due to the length of the texts of the federal and state statutes, and the state regulations involved in this case, the pertinent texts are set out in the Appendix attached hereto at pp. A-75 through A-94.

	Page No.
1. 42 U.S.C. 1395 p.	A-75
2. 42 U.S.C. 1395 q.	A-76
3. 42 U.S.C. 1395 y.	A-77
4. 26 U.S.C. 5000	A- 79
5. 42 U.S.C. §300bb-1 - 300 bb-8	A-79, A-92
6. N.Y. Civil Service Law §163(3)	A-92
7. N.Y. Civil Service Law §165(1)	A-93
8. N.Y. Civil Service Regulations 73.2	A-93, 94

CONSTITUTION OF THE UNITED STATES:

Article VI

---------o---------

Paragraph 2

...This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made or which shall be made, under the Authority of the United States

shall be the Supreme Law of the Land; and the Judges in every State shall be bound thereby; any thing in the Constitution or laws of any State to the contrary not withstanding.

(g) STATEMENT OF THE CASE

----------o----------

Petitioner's original Complaint, dated December 30th 1997, was filed, together with its annexed summons, in the Supreme Court of the State of New York, Monroe County (Rochester), on January 6th, 1998. The Complaint alleged, in respect to the Respondents herein, New York State Department of Civil Service, Metropolitan Life Insurance Co., and United Healthcare Corporation, four separate and distinct causes of action. They were as follows:

Action No. (1): A claim that the regulations and the provisions, including the language in the insurance certificate, constituting the terms of the New York State Health Insurance Plan (NYSHIP) which the Department of Civil Service had approved and implemented with the Respondents, Metropolitan and United Healthcare, known as the Empire Plan, were contrary to, and inconsistent with, the provisions of Title 42 U.S.C. 1395 p & q, and that plaintiff had not waived his federal rights thereunder, and that, accordingly, they were void and ineffective as to their assumptions of his coverage of Medicare B.

Action No. (2): (Solely a claim under New York State Laws)

Action No. (3): (Solely a claim under State Law and the common law of third party contracts).

Action No. (4): A claim that the practice of Respondents, Metropolitan, United Healthcare, and Department of Civil Service, which, for purposes of making Medicare B the primary payor for participants in the Empire Plan, assumed that commencement of coverage under the Medicare B statutes had occurred for each participant as of the earliest possible date under the provisions of 1395 q, regardless of whether the participant had, in fact, enrolled in Medicare B during the initial enrollment period, at a time early enough to accomplish coverage as of that earliest possible date, was a violation of the provisions of subchapter XX of Title 42 U.S.C. §300 bb-1, et

seq., specifically, 42 U.S.C. 300 bb-2, subpar. (2)(D)(ii).

Accordingly, petitioner raised the federal questions as to which he seeks review in this Court at the very outset of this civil action, to wit, at the time he filed his summons and complaint. A copy of the petitioner's complaint appears in the Appendix at pages A-13 through A-48.

The court of first instance was the only court to express an opinion, and to pass upon, these federal questions, in an expository written statement. That written opinion appears in the Appendix at page A-1 through A-8.

As to the first cause of action, the Court held that the State's only obligation to the petitioner was to "adequately notify him of the requirement that he enroll in Medicare Part B prior to his 65th birthday." The Court went on to hold that the Notices in the record were adequate for this purpose. The Court ignored defendant's Department of Civil Service admissions in the Affidavit of Christine Williams, its employee, that:

(1) Under NYSHIP rules, those who are eligible for Medicare Part B must enroll to avoid reduced health insurance coverage, because NYSHIP benefits become secondary based on an individual's eligibility for Medicare Part B, not on their actual enrollment in it. Appendix p. A-62

and

(2) The NYSHIP underwriting control assumptions for the Empire Plan have included an assumption that NYSHIP will become secondary payor to Medicare as of the first possible Medicare effective date a NYSHIP enrollee can have under the federal rules which is...the first day of the month in which his 65th birthday occurs. Appendix p. A-65-A-66

Moreover, the Court ignored petitioner's contentions that it was a question of federal law whether a NYSHIP enrollee had waived (and adequacy of notice is a waiver issue) his right to

enroll in Medicare B at any time during the initial enrollment period in order to comply with NYSHIP assumptions as to coverage under Medicare B as of the earliest possible date, and its notices to enroll "when first eligible".

As to the fourth cause of action, the Court held that subchapter XX of Title 42 did not apply to the petitioner. This conclusion of law notwithstanding, the following facts are not controverted in this case:

(1) Petitioner was a State employee, enrolled in NYSHIP, for over ten years from 1982-1992.
(2) Petitioner left State Judicial office honorably in January, 1992 at the end of his elected term.
(3) Petitioner would have lost his NYSHIP medical insurance coverage in January 1992 had he not exercised his rights under State Laws, to continuation coverage. N.Y. State Civil Service Law, §165, subparagraph 1.
(4) State law did not terminate petitioner's continuation coverage at the expiration of 18 months, as allowed in §300 bb-2, but authorized indefinite continuation so long as petitioner paid the premiums. N.Y. Civil Service Law §163, subparagraph 3, also Rule 73.2(a)(3).

All of which meant that N.Y. State law had complied with the provisions of Title 42 U.S.C. §300 bb-3, subparagraph (2) §300 bb-5, subparagraphs (1) and (2); and §300 bb-1. It is significant that the federal law only requires that the qualified beneficiary "would lose coverage under the plan as a result of a qualifying event" not, as the Court below stated, that an enrollee "must first lose insurance coverage due to ... the termination of employment." It is true petitioner did not lose insurance coverage after he left office because he properly exercised his rights under State law to "continuation coverage" as the Federal statute required. See Opinion of the Court, Appendix at p. A-8.

* * *

* * *

There are no material facts in dispute in this case. The petitioner elected to continue in NYSHIP Empire Plan's medical insurance after he left state office in 1992. He made all his insurance premiums payments thereafter. (R. pp. 356-357). He became 65 years of age on April 18th, 1997, his date of birth being April 18, 1932. He applied for Medicare B in July, 1997, within his initial enrollment period.

From early 1992, when petitioner left State Judicial office, until the end of 1997, petitioner served as a County Attorney for Monroe County (Rochester) New York. He remained an employee of a political subdivision of New York State throughout the entire relevant time period alleged in the Complaint. The County, however, had a different group health insurance plan, so the petitioner chose to exercise his right to continue his coverage under NYSHIP.

In August 1997, petitioner was diagnosed with rectal carcinoma. Petitioner received medical and surgical services at Roswell Park Cancer Institute in Buffalo. Respondents refused to pay that part of petitioner's medical bills which Medicare B would have paid if it had been in effect - approximately $15,000; they paid only what was due over and above that sum. Petitioner's continuation medical coverage under NYSHIP went from primary to secondary on April 1st, 1997 under NYSHIP rules and assumptions. Petitioner's Medicare B coverage commenced October 1st, 1997, as §1395 q provides since he enrolled in Medicare in July 1997. There was, accordingly, a six-month gap in primary medical insurance coverage, during which time period petitioner incurred substantial medical expenses. Petitioner alleges money damages as a result of that gap in primary coverage.

Furthermore, petitioner seeks to represent a class of about 250 other participants in NYSHIP. Respondents admit that from1992-1997, inclusive, approximately 188 other members were denied primary medical coverage because of a failure to

enroll promptly in Medicare B. This figure translates into about 31 claims a year. Consequently, as of January, 2000, Respondents had denied 250 claims from NYSHIP participants over the previous eight years[1].

Finally, both Courts below ignored petitioner's arguments that NYHIP had failed to comply with the notice requirements imposed on NYSHIP by 42 U.S.C. §300 bb -6.

The Appellate Division - the Court to whom petitioner has sought the issuance of this Writ of Certiorari - merely affirmed, unanimously, the opinion of the Court of first instance "for the reasons stated in the decision at Supreme Court, Corning, J." The order of affirmance is dated June 8th, 2001.See Appendix, at p. A-9, A-10..

Petitioner moved for leave to appeal to the N.Y. Court of Appeals, the Court of last resort in N.Y. State, on July 3rd, 2001. That Court denied the motion, by order, on September 20th, 2001. See Appendix at p. A-11, A-12.

Under Rule 13, subparagraph 1, this petition is timely if petitioner files it on our before December 19th, 2001.

---

[1] Respondents in January 2000, published a revised set of notices to its participants in its insurance certificate. Under State law, the revised notices end the class affected by the former notices.

(h)Argument specifying the Reasons for Granting the Writ

Rule 10 lists three general propositions for persuading this Court to grant a petition for a Writ of Certiorari. Neither subparagraph (a) nor (b) of that Rule applies to this case. Only the proposition that the Courts below, and certain Courts of Appeal, have decided an important question of federal law that this Court should settle applies to this Case.

The fact, however, is that the Courts below have utterly ignored the federal statutes the petitioner has invoked, or have decided, wrongly, that they do not apply.

Members of this Court - principally the Chief Justice - have permitted television interviews on C-Span over the years which have delved at length into the internal process the Court uses to decide whether to grant the petition. It is not enough, says the Chief Justice, that the Courts below have wrongly decided the case. Were that the template, the Court's calendar would have no end. More is needed. There must be an important question of federal law to clarify or to settle.

Of course, what can be gleaned from these principles is actually a two-fold guideline. First, the Court will never grant the Writ if the Court below has decided the case correctly. Second, this Court must be persuaded that in deciding the case incorrectly, the Courts below have trampled upon federal laws in an egregious and unpardonable manner so significantly as to "call for an exercise of this Court's supervisory powers" or that they have dealt erroneously with an important question of federal law that this Court should settle to the contrary. Petitioner will now argue that the latter principles exist in this case.

(1) The Decision Below is egregiously erroneous
(1) §1395 p. and q.

Respondents have successfully argued below that their insurance certificates informed the petitioner that he must enroll in Medicare B prior to his 65th birthday and have coverage in effect

at the earliest possible date under the federal rules. They scoff at petitioner's contention that a State cannot, by statute, regulation, or group health insurance plan, abbreviate the seven-month initial enrollment period of §1395, which that federal statute grants to individuals when they attain age 65. They assert that the Plan's certificate does not shorten the period, it merely eliminates the Plan's primary medical insurance coverage as of the earliest possible Medicare effective date under the federal rules. Petitioner replies that the advisory to enroll "when first eligible" is insufficient as a matter of law to deprive an enrollee of his federal statutory right to enroll at any time during the initial enrollment period.[2] Moreover, petitioner claimed that how a state-authorized group health insurance plan compelled Medicare enrollment, and entitlement to Medicare B benefits, to become effective at the earliest possible date, was primarily a question of federal law, not State law.

One of the notices appears in the Court's opinion (at Appendix p. A-7). It states:

> "If you are no longer an active employee, contact your local social security office three months before you or your spouse turns age 65, to arrange for enrollment in Medicare Parts A & B. Once you or your spouse has enrolled, Medicare coverage becomes effective on the first day of the month in which you reach age 65."

---

[2] The notices which respondent supplied to its participants in NYSHIP are subject to two statutes one State and one Federal. The Courts below have held that under Section 162, subparagraph 5 of the N.Y. Civil Service Law, the advisories in the Certificate to enroll in Medicare "when first eligible" convey information to each participant sufficient to tell him to have Medicare B in effect on the 1st day of the month he turns 65. That statute, accordingly, is no longer an issue in this case as its interpretation is solely a question for State law. Interpretation of the Federal statute is, however, the prerogative of this Court. Title 42 U.S.C. 300 bb-6 requires respondents to advise beneficiaries of their "rights under this subsection (subch. XX)". In that regard, the notices in the Certificates are inadequate as a matter of law.

Respondents have succeeded in persuading the Courts below that this notice is adequate to inform petitioner that he:

(1) MUST enroll in Medicare B during the first three months of his initial enrollment period, and not afterwards.
(2) MUST have Medicare B in effect on the 1st day of the month he turns 65
(3) WILL LOSE primary medical insurance coverage under NYSHP on the 1st day of the month he turns 65 regardless of whether he has enrolled by then in Medicare B.

But, of course, the notice does not even mention the initial enrollment period of seven months' duration, the documentation required for enrollment, nor the variations in the effective dates of Medicare B coverage depending on when enrollment occurs, nor does it advise that primary medical insurance coverage under NYSHIP will end under the plan on the earliest possible effective date under the federal rules regardless of whether enrollment and/or entitlement to Medicare benefits has occurred by that time. Therefore, what the notice states is true ONLY for Medicare A, not Medicare B, because enrollment at any time during the initial enrollment period relates back to the 1st of the month one turns 65 only for Medicare A.

Moreover, the petitioner, when he turned 65, was in NYSHIP under his federal statutory right to continuation coverage. Termination of continuation coverage - and elimination of primary medical coverage, is a termination - can occur under §300 bb-2, subparagraph(2) (D)(ii), only after a qualified beneficiary has become "entitled to benefits under Title XVIII." (42 U.S.C. §1395 et seq.) But that part of Subchapter XX of Title 42 was ruled inapplicable, and was ignored.

Finally, petitioner was an active employee at the time he turned 65, working for a political subdivision of N.Y. State, to wit, the County of Monroe (Rochester). Moreover, under N.Y. Civil Service Rules, §73.2, subparagraph (a), his status "as an

employee is deemed to continue" while he is a vestee. Accordingly, under those State statutes and regulations, he was an active employee, and was within the meaning of the definition of "active employee" under the Medicare as Secondary Payor Act, 42 U.S.C. 1395 y, subparagraph (b)(1)(A)(i)(I) and (II), and subparagraph (b)(1)(E)(ii). That statute forbids shifting primary health insurance coverage from the private insurance carriers to the Medicare program for participants in petitioner's class, who have retained, under State law and regulations, their status as employees[3].

(2) 42 U.S.C. §300 bb-1 through §300 bb-8; 42 U.S.C. 1395 y, subpar(b)

——— o ———

What is not in dispute in this case is that NYSHIP was obliged to provide some form of medical insurance coverage to petitioner, Respondents claim that coverage was secondary to Medicare. Petitioner claims it was primary and Medicare was secondary.

The Court below held that:

> "In order to utilize the provisions of COBRA, an insured must first lose insurance coverage due to a certain enumerated event, such as a termination of employment, or the death of a covered spouse. See 42 U.S.C. 300 bb-1. Plaintiff here can point to no such qualifying event. His insurance coverage was never lost, but, rather, it became secondary to Medicare Part B when he reached age 65. Hence, he cannot make an argument that the provisions of COBRA were violated in his case, as these provisions do not even apply to his case." See Appendix at p. A-8

If what the Court held is the truth and the original coverage still

---

[3] Probably, but not certainly, the Medicare as Secondary Payor Act, applies to large group health insurance plans operated by State and Federal governmental agencies since 26 U.S.C. 5000, subpar(d) is inapplicable under title 42 U.S.C. 1395y, subparagraph(b)(1)(i)(v), p A-78

existed then NYSHIP has violated the provisions of the Medicare as Secondary Payor Act, 42 U.S.C. 1395 y, subparagraph (b)(1)(A)(i) which forbids discriminating between those 65 and older, and those younger than 65, who have health insurance coverage by virtue of their similar "current employment status with their employer". N.Y. Civil Service Rules 73.2, subparagraph (3) does continue Petitioner's status as an employee of N.Y. State, for this purpose.

But if, as the facts admitted herein prove, Petitioner was exposed to a risk of losing his NYSHIP medical coverage when he left judicial office in January, 1992 (See N.Y. Civil Service Law, §165, subparagraph 1), unless he chose to continue such coverage and pay the premiums therefor, which he did do, then that event was a "qualifying event" under 42 U.S.C. §300 bb 3, and accordingly, all the provision of subchapter XX of Title 42 applied to the Petitioner. This is the petitioner's contention and it presents a federal question this Court should settle.

Certainly the Court below erred when it held this statute did not apply to petitioner. At the expiration of his elected term, in 1992, petitioner left State judicial service under honorable conditions. Cf. Larsen v. Senate of Comm of Pa, 154 F.3rd 82 (C.A. 3rd 1998). That triggered the provisions of §300 bb-3, subpar. (2) regarding termination of his employment as a qualifying event. His election to continue in NYSHIP under State laws and regulations (N.Y. Civil Service Law §163, subpar. 3) was an exercise of his federal statutory rights. Since petitioner paid the NYSHIP premiums, throughout the following years, his coverage continued, and is still in effect at this time, the State of N.Y. having waived its federal statutory right to limit coverage to 18 months.

The only change in those years (1992-2001) in Petitioner's NYSHIP continuation coverage was the reduction to secondary payor status for NYSHIP when petitioner enrolled in Medicare. But that reduction occurred before petitioner was entitled to the benefits coverage under Medicare B, and it was NYSHIP's policy to effect the reduction to secondary payor status based on

the Medicare eligibility of its participants not on their entitlement to Medicare benefits. See Affidavit of Christine Williams for Respondent Department of Civil Service, par 20. Appendix at p. A-62.

NYSHIP's policy is a direct violation of Subchapter XX of Title 42 of the United States Code, section 300 bb-2, subparagraph (2)(D)(ii) which forbids ending any part of continuation coverage prior to the date the qualified beneficiary becomes entitled to Medicare benefits.

The Court should pay particular attention to the phrase "entitled to benefits" in §300 bb-2(D). As originally drafted in 1986, this phrase read "eligible for benefits". However, in 1989, Congress amended the section to delete the phrase "eligible for benefits" and it substituted "entitled to benefits". See 1989 Stat. 101-239.

Also, by statutory definition, in a termination of employment event, the covered employee (petitioner) is a "qualified beneficiary". See 42 U.S.C. 300 bb-8, subparagraph (3)(B).

* * *

The most important federal issue in this case does not surface in the Record because the Respondents never raised it, and because the Court below held that subchapter XX did not apply since the petitioner never lost his insurance coverage, it was only reduced to secondary payor status.

As to the lower Court's reduction of benefits finding, the federal statute is clear. Continuation coverage must be identical to the coverage provided under the plan as to participants who have not experienced a "qualifying event." §300 bb-2, subpar. (1). That means primary medical coverage and nothing less. Secondary payor status or full termination of coverage can occur only after a qualified beneficiary becomes entitled to Medicare benefits. §300 bb-2, subpar. (2)(D)(ii). Moreover, it is not necessary to lose insurance coverage in order to come under the protection of subchapter XX. It is only necessary that the

qualifying event triggers a risk of loss of such coverage. See N.Y. Civil Service Law §165, subpar. 1.

The major issue is the question of 18 month's duration of continuation coverage. In Oakley v. City of Longmont 890 F.2d 1128 (C.A. 10th 1989) that Court held:

> "We turn to the subsection at issue in this appeal, 42 U.S.C. §300 bb-2(2), the period of continuation coverage. Continuation coverage automatically terminates after the maximum period of coverage permitted, 18 months from the date of the qualifying event." See 890 F.2d at p. 1132.[4]

Under New York Law, persons in petitioner's situation are entitled to continue participation in NYSHIP indefinitely, so long a they continue to pay their medical insurance premiums. At the time petitioner elected to continue under NYSHIP Empire Plan (1992) the Respondents did not, indeed under State Law could not, notify him that his continuation coverage would end after 18 months. §300 bb-6 would mandate such a notice if that were the case. Accordingly, continuation coverage extended beyond the mandatory 18-month period.

In the Courts below, petitioner argued that any State can provide continuation coverage voluntarily beyond 18 months as New York has done. In that event, the other sections of §300 bb-2 continue in force so long as the notices required under §300 bb-6 are issued to that effect. What that means in this case is that the NYSHIP notices had to tell participants in the plan that medical coverage would become secondary when they became "entitled to Medicare B benefits[5]." And, certainly, the NYSHIP plan could not end primary coverage upon an assumption of the participant's entitlement to Medicare B, at the earliest possible

---

[4] Compare however the same Court's language on p. 1131: "...coverage must extend for at least eighteen months from the date of the qualifying event." 890 F.2d 1128, at p. 1131.

[5] 42 U.S.C. 300 bb-2, subpar(2)(D)(ii).

date under §1395 q.

Moreover, on the question of adequate Notice, petitioner's efforts to draw the attention of the Courts below to comparable federal cases under ERISA, e.g. Layou v. Xerox Corp. 238 F.3rd 205(2nd cir. 2001) and Santana v. DeLuxe Corp. 12F. Supp2d 162, (U.S.D. Ct. Mass. 1998), a comparison federal Courts of Appeals have corroborated, (Oakley v. City of Longmont, 890 F.3rd 1128 at p. 1131), were to no avail whatsoever. Notices under §300 bb-6 and summary plan descriptions under 26 U.S.C. 1022, function exactly as §300 bb-6 demands, and these ERISA cases were pertinent on that question.

(3) The Record Raises Important Questions of Federal Law that this Court should clarify and settle.

Virtually every section of subchapter XX of Title 42 of the United States Code is implicated in this case. The questions are:

1. Whether the provisions of the federal statute continue after expiration of the 18-month mandatory period, when the State voluntarily extends the period of continuation coverage beyond 18 months.
2. Whether a change of medical insurance coverage from primary to secondary is a "termination" of coverage under §300 bb-2.
3. Whether a group health plan for any State may effect a "termination" of primary medical coverage upon an assumption that Medicare B has become effective for its participants" as of the earliest possible date the participant is eligible under the federal rules, regardless of whether Medicare B is in effect and the beneficiary "entitled to benefits" at that time.
4. What are the essential contents of the notices §300 bb-6 requires at the commencement of continuation

coverage?

5. Whether §300 bb-7 authorizes this action for equitable relief to be brought in a State Court, as a Class action.

Moreover, the questions pertaining to the process of relinquishment of the federal rights conferred on individuals turning 65 years of age under §1395 p. and q. of Title 42 as to their enrollment in the Medicare program, and substitution of Medicare as the primary payor under a State group health insurance plan, are also presented to the Court, as are the proscriptions contained in the Medicare as Secondary Payor Act.

* * *

There are millions of senior U.S. citizens becoming Medicare eligible and dependent every year. Medicare is the largest single item in the domestic federal budget.

This case - and this Court's decision if certiorari is granted - will affect the group health plans of every present State's, and its political subdivision's, employees in the nation. And it will both impact on the Medicare budget, and on the duties of health insurance carriers for all State and local government employees enrolled in their group health insurance plans.

The statutes involved here have received little judicial attention. Individual violations of their provisions usually involve minor amounts of money, so litigation about them is sparse. This case is a rare exception to that otherwise general rule. But the widespread importance of these statutes is undeniable.

CONCLUSION

Petitioner prays that the Court grant the Writ.

DATED: ~~Nov. 30~~ Dec 11, 2001

Respectfully submitted:

James A. Robinson

James A. Robinson, Esq.
Attorney for Petitioner
19 Main Street West
Suite 800
Rochester, New York 14614
(585)546-8880-

TO: Eliot Spitzer, Esq.
Attorney General of the State of New York
Attorney for Defendant
The Capital
Albany, New York 12224
Telephone (518)473-7712

Moran & D'Arcambal
Siobhan Moran, Esq.
265 Sunrise Highway
Suite 61
Rockville Centre, New York 11570
Tel:(516)678-6660

STATE OF NEW YORK
SUPREME COURT COUNTY OF MONROE

JOHN MANNING REGAN, on behalf of himself and all other vestees within the New York State Health Insurance Plan who are similarly situated,

Plaintiff

v.

Index No. 90/98

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE, ALBANY, N.Y.; METROPOLITAN LIFE INSURANE CO., INC.; UNITED HEALTHCARE SERVICE CORP. and WILLIAM J. BROREIN, M.D.

Defendants.

BEFORE: HON. PETER E. CORNING
Acting Justice Supreme Court

APPEARANCES: ELIOT SPITZER
Attorney General of the State of New York
Attorney for the New York State Department of Civil Service
EMIL J. BOVE, JR.
Assistant Attorney General of Counsel
144 Exchange Boulevard
Rochester, N. Y. 14614

SIOBHAN E. MORAN
Moran & d'Arcambal
Attorneys for Metropolitan Life Insurance Company, Inc. & United Healthcare Corp.
64 Wright Road

Rockville Centre, New York 11570

JAMES A. ROBINSON, ESQ.
Regan & Regan, P.C.
Attorneys for John Manning Regan
19 Main Street West, Suite 800
Rochester, New York 14614

Plaintiff served as a state employee for ten and one half years, from April 6, 1967 to September 28, 1967, and from January 1, 1982 until January 1, 1992. Once he left state service in 1992,he continued to pay health insurance premiums, but rarely used the insurance plan, and was admittedly not familiar with its terms. Specifically, plaintiff alleges that he was unfamiliar with the provision of the New York State Health Insurance Plan (hereinafter NYSHIP) that requires participants who have attained the age of 65 to enroll in Medicare. From the age of 65 on, Medicare becomes the primary insurer, and NYSHIP pays those costs not covered by Medicare. Those who fail to enroll in Medicare must cover the costs of any service which would have been covered by Medicare.

Plaintiff turned 65 on April 18, 1997, but did not enroll in Medicare until July, 1997. Due to his delay, there was a three month waiting period, and his coverage did not commence

until October 1, 1997. Unfortunately, on August 4,1997, plaintiff was diagnosed with rectal carcinoma. Due to his failure to enroll in Medicare on or before his 65th birthday, plaintiff became responsible for certain costs incurred in treating his condition that would have otherwise been covered by Medicare.

This action was commenced on January 6, 1998, when plaintiff filed a complaint against defendants which alleged four causes of action, as follows: 1) the certificate of insurance issued to plaintiff did not adequately inform him of the requirement that he enroll in Medicare Part B, and effectively shortened the length of the initial enrollment period for Medicare benefits; 2) defendant Department of Civil Services failed to reimburse him for Medicare Part B premiums until after his medical claims arose; 3) defendants violated their contractual duties to inform plaintiff of the plan's benefits and features; and 4) defendants violated the provisions of Title 42 USC §300bb-1 through 300bb-8 (hereinafter COBRA) which require that group health plans must extend coverage, after a qualifying event until the beneficiary becomes eligible for

benefits under the Social Security Act. Plaintiff has also brought a medical malpractice action against William J. Brorein, M.D., which is not the subject of the motions currently before this Court.

Defendant first moved for summary judgment in the Summer of 1998. That motion was "denied without prejudice to a renewal thereof upon completion of discovery proceedings" by Justice Henry Scudder. The parties were allowed 120 days to complete discovery. In the interim, Justice Scudder was moved to the Appellate Division, Fourth Department, and this matter was transferred to this Court for resolution. Discovery was ended on or about November 10, 2999, a year after the Order from Justice Scudder giving the parties 120 days to complete discovery.

Defendants have now renewed their motions for summary judgment seeking to dismiss plaintiff's firs and third causes of action on the grounds that plaintiff was well informed of the requirement to enroll in Medicare Part B prior to his 65th birthday, hence, no violations of state law or contractual duties occurred, defendant Department of Civil Service seeks to

dismiss plaintiff's second cause of action on the grounds that all Medicare premiums paid by plaintiff have been reimbursed to him and defendants seek to dismiss plaintiff's fourth cause of action alleging violations of COBRA on the grounds that COBRA is not applicable to the situation at hand.

Plaintiff has countered these arguments by first alleging procedural defects in that the doctrine of "law of the case" precludes this Court from deciding on these issues, as they have already been addressed by Justice Scudder, and that discovery was inappropriately cut short by this Court. Plaintiff then argues again that the Certificate of Insurance did not adequately inform him of the necessity to enroll in Medicare Part B, and alleges violations of COBRA. The Court heard oral argument on this motion on April 24, 2000, and, for the reasons set forth below, has determined that defendants' motion for summary judgment should be granted in its entirety.

To address the procedural concerns raised by plaintiff, this Court is of the opinion that neither argument has merit. The law of the case doctrine which bars a court of coordinate jurisdiction from deciding issues previously decided in another

case is not applicable here. Collins v. Olsher McLain, Ltd. 22 AD2d 485. Justice Scudder specifically contemplated a renewal of defendants' motion for summary judgment once discovery was finished. Furthermore, the issues herein were not decided by Justice Scudder, but were postponed pending the completion of discovery. Therefore, this Court is not now barred from deciding the issues presented herein.

Plaintiff further contends that he was not allowed adequate time for discovery, and that this Court improperly cut the discovery process short. It should be noted that plaintiff had over a year to conduct discovery, and, in that time, admittedly received at least forty pounds of documents from one defendant alone. One year is certainly ample time to conduct any discovery necessary, and this Court was well within its discretion to end the discovery process after that year had passed.

Plaintiff's first and third causes of action basically allege that defendant failed to adequately notify him of the requirement that he enroll in Medicare Part B prior to his 65th birthday. However, plaintiff was informed in over (20) publications and

direct mailings of this requirement. For instance, as plaintiff points out in his brief in opposition to this motion, these publications included such language as "if you are no longer an active employee, contact your local Social Security office three months before you or your spouse turns 65 to arrange for enrollment in Medicare Part A&B." Plaintiff admittedly failed to familiarize himself with the terms of his insurance policy. Given these circumstances, plaintiff cannot now claim that defendants violated their duty to inform him of the requirement to enroll in Medicare Part B. Therefore plaintiff's first and third causes of action based on defendants' failure to inform him of his requirement, are hereby dismissed.

Plaintiff's second cause of action alleges that he has not bee properly reimbursed for the Medicare Part B premiums by defendant Department of Civil Service. Records show, however, that plaintiff has been reimbursed for these expenses. Therefore, this cause of action should be dismissed as well.

The fourth cause of action asserted by plaintiff alleges that defendants violated the provisions of COBRA by failing to extend his insurance coverage until his Medicare Part B

coverage was available. In order to utilize the provisions of COBRA, an insured must first lose insurance coverage due to a certain, enumerated event, such as the termination of employment, or the death of a covered spouse. See 42 U.S.C. §300bb-1. Plaintiff here can point to no such qualifying event. His insurance coverage was never lost, but, rather, it became secondary to Medicare Part B when he reached age 65. Hence, he cannot make an argument that the provisions of COBRA were violated in his case, as these provisions do not even apply to his case.

Accordingly, based upon the foregoing, it is hereby

ORDERED that defendants' motion for summary judgment is granted in its entirely, and that the plaintiff's first, second, third and fourth causes of action are dismissed.

Dated: May 8th, 2000

s/ Peter E. Corning
Peter E. Corning
Acting Justice Supreme Court

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION, FOURTH JUDICIAL DEPARTMENT

PRESENT: GREEN, J.P., PINE, HURLBUTT,KEHOE AND BURNS, JJ.

CA 00-02529
JOHN MANNING REGAN, ON BEHALF OF HIMSELF AND ALL OTHER VESTEES WITHIN THE NEW YORK STATE HEALTH INSURANCE PLAN WHO ARE SIMILARLY SITUATED,
PLAINTIFF-APPELLANT

V

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE, METROPOLITAN LIFE INSURANCE COMPANY, UNITED HEALTHCARE SERVICE CORP., DEFENDANTS-RESPONDENTS, ET AL,
DEFENDANT
(APPEAL NO. 2)

John Manning Regan, on behalf of himself and all other vestees within the New York State Health Insurance Plan who are similarly situated, having appealed to this Court from the order of the Supreme Court, entered in the Monroe County Clerk's Office on June 14, 2000, and said appeal having been argued by James A. Robinson of counsel for plaintiff-appellant, Kathleen M. Treasure of counsel for defendant-respondent New York State Department of Civil Service, Andrew P. Karamouzis

of counsel for defendants-respondents Metropolitan Life Insurance Company and United Healthcare Service Corp., and due deliberation having been had thereon,

It is hereby ORDERED that the order so appealed from be and the same hereby is unanimously affirmed without costs for reasons stated in decision at Supreme Court, Corning, J.

Entered: June 8, 2001 CARL M. DARNALL, Clerk

STATE OF NEW YORK
COURT OF APPEALS

At a session of the Court, held at Court of Appeals Hall in the City of Albany on the twentieth day of September 2001

PRESENT, Hon. JUDITH S. KAYE, Chief Judge, presiding

4-10 Mo. No. 878
John Manning Regan, &c.
Appellant,
v.
New York State Department of Civil Service, et al,
Respondents.
(Appeal No. 1)

Regan v NYS Dept. of Civil Service
(Appeal No. 2)

A motion for leave to appeal to the Court of Appeals in the above causes having heretofore been made upon the part of the appellant herein and papers having been submitted thereon and due deliberation having been thereupon had, it is

ORDERED, that the said motion, insofar as it seeks leave to appeal from the Appellate Division order that affirmed Supreme Court's order terminating discovery, be and the same hereby is dismissed upon the ground that such order does not finally determine the action within the meaning of the

Constitution; and it is

ORDERED, that the said motion for leave to appeal otherwise be and the same hereby is denied.

Judge Wesley took no part.

S/ Stuart M. Cohen
Stuart M. Cohen
Clerk of the Court

STATE OF NEW YORK
SUPREME COURT COUNTY OF MONROE

JOHN MANNING REGAN, ON BEHALF OF HIMSELF, AND ALL OTHER VESTEES WITHIN THE NEW YORK STATE HEALTH INSURANCE PLAN, WHO ARE SIMILARLY SITUATED;
29 HOYT PLACE
ROCHESTER, NEW YORK

Plaintiff

v.

VERIFIED COMPLAINT
Index No. 90/98

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE, ALBANY, N.Y.; METROPOLITAN LIFE INSURANE CO., 1 MADISON AVE., NEW YORK CITY, NEW YORK; UNITED HEALTH CARE SERVICES CORPORATION, AS ADMINISTRATOR. 505 BOICES LANE, KINGSTON, NEW YORK; AND WILLIAM J. BROREIN, M.D., 2265 SOUTH CLINTON AVE., ROCHESTER, NEW YORK

Defendants.

Plaintiff, by his attorney James A. Robinson, Esq., of counsel to Regan & Regan, P.C., complaining of the defendants on behalf of himself and all other *vestees* of the New York State Health Insurance Plan (NYSHIP) who are similarly situated, allege as follows:

FIRST: Plaintiff is a resident of the State of New York,

County of Monroe and City of Rochester.

SECOND: Upon information and belief, defendants, Metropolitan Life Insurance Co. and United Health Care Services Corporation are corporations licensed to do business in the State of New York, having offices at the addresses indicated above; defendant, New York State Department of Civil Service, is an agency of the State of New York headquartered in Albany; defendant, William J. Brorein, is a physician and a resident of Monroe County.

THIRD: Plaintiff brings this action on behalf of himself and on behalf of all other *vestees* of the New York State Health Insurance Plan similarly situated.

FOURTH: (a) The class of *vestees* is so numerous that joinder of all its members is impractical. A *vestee* in the New York State Health Insurance Plan (NYSHIP) is a former State Employee whose service as a state employee terminated at a time when he was entitled to a vested retirement allowance, but who for whatever reason, at the time of his termination, deferred to a later time the payment of his retirement allowance. This situation happens principally to elected officials whose

term of office ends prior to their eligibility for, or their decision to accept, a retirement allowance, but whose years of service in State employment have entitled them to a vested retirement allowance. Plaintiff herein, at all times hereinafter mentioned, is such a *vestee*. Plaintiff has no way of knowing the size of this class, but alleges that defendant, New York State Department of Civil Service, possesses such information. Upon information and belief, the class contains hundreds of members.

(b) The class was created by the State Legislature in 1966 when, in enacting LAWS, 1966, c. 27 it authorized the President of the Civil Service Department to establish regulations permitting *vestees* to continue to participate in NYSHIP. It originally obliged all *vestees* to pay the full cost of such health insurance coverage, but that provision has since been modified by Laws, 1969 c. 36, which requires the State to pay the insurance premiums for some *vestees*. Regulation 73.1, subparagraph (g), of the Rules and Regulations of the Department of Civil Service acknowledges the status of *vestee* in accordance with the enabling statute.

FIFTH: In this civil action, there are common questions

of law and fact pertinent to the class which predominate over any questions affecting only the individual members of the class.

SIXTH: The claim of the plaintiff herein is typical of the claims of the entire class, and the plaintiff can fairly and adequately protect the interests of the class.

SEVENTH: A class action is superior to other available methods for the fair and efficient adjudication of the issues raised hereinafter in this Complaint.

AS AND FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS: NEW YORK STATE DEPARTMENT OF CIVIL SERVICE, METROPOLITAN LIFE INSURANCE CO., AND UNITED HEALTH CARE SERVICES CORPORATION, PLAINTIFF ALLEGES:

a. Operative Facts

EIGHTH: Plaintiff served as a State employee from April 6, 1967 until September 28th, 1967 and from January 1st, 1982 until January 1st, 1992, attaining approximately ten and one-half (10 1/2) years of service by January, 1992. At that time, plaintiff, due to expiration of his elected term, left State service, but was vested in entitlement to a retirement allowance, having served the minimum period of ten (10) years.

Accordingly, under Section 163, subparagraph 3, of the Civil Service Law, plaintiff elected to continue tin NYSHIP, as a *vestee*, who was also at that time currently entitled to a retirement allowance, but who deferred receipt of that allowance. Plaintiff was 59 years old at the time he terminated his State employment.

NINTH: The New York State Health Insurance Plan (NYSHIP) is a group health insurance policy. The policyholder is the State of New York, Department of Civil Service, the defendant herein. The insurer, in this case for medical benefits only, is the Metropolitan Insurance Co., co-defendant herein. The beneficiaries are the New York State Employees, active, vested or retired, whose membership constitutes the group. The beneficiaries do not receive a copy of the group health policy. They receive a certificate of insurance, which summarizes the provisions of the policy. Under the rules and regulations of the Department of Civil Service, that defendant has the duty to prepare and distribute these certificates of insurance for its employees, and "such other materials as may be required in connection with the

administration of the Plan." See Rules of the New York State Department of Civil Service Section 73.4.

TENTH: In accordance with his election to continue in NYSHIP, plaintiff continuously made or tendered his premium payment to NYSHIP from January, 1992 through 1997 for himself and his wife. During those years, plaintiff rarely qualified for health benefits and, because of that fact, had little familiarity with the provisions of the plan.

ELEVENTH: Upon information and belief, an important provision of the health insurance plan (NYSHIP) requires *vestee* certificate beneficiaries, and their dependents, to enroll in Medicare when they become 65 years old. The relevant language of the insurance certificate follows:

> "When you are eligible for primary coverage under Medicare the benefits under this plan will change.
>
> Please refer to the General Information section of this book for information on when you MUST enroll for Medicare, and when Medicare becomes your primary coverage. If you and your dependent are eligible for primary Medicare coverage - even if you fail to enroll - your covered medical expenses will be reduced by the amount available under Medicare..."

The referenced language of the general information booklet

(pages 23, 24 and 25) is attached hereto, made a part hereof, and marked Exhibit (1). Two paragraphs of those three pages pertain to the plaintiff as ***vestee***. Said paragraphs appear at p. 23 of Exhibit (1). The first paragraph, in the left-hand margin, states:

> "You and your dependents must enroll when eligible for primary Medicare coverage."

The second paragraph appears within the bracketed language on p. 23, and says:

> *Empire Plan Enrollees:* The Empire Plan will not provide any benefits for coverage available under Medicare. If you or a dependent is eligible for primary Medicare coverage but does not enroll, you will be responsible for the full cost of medical services that Medicare would have covered.

Annexed hereto and made a part hereof, and marked Exhibit (2), is the latest amended information booklet language pertaining to vestees and to this topic of Medicare enrollment. That booklet is dated December, 1996 and it advises ***vestees*** of their duty to enroll in Medicare, when they are eligible.

TWELFTH: Federal laws govern enrollment in Medicare. The pertinent United States Code sections are: Title

42, United States Code, Section 1395 p. A true copy of this section is annexed hereto, made a part hereof, and marked Exhibit (3).

THIRTEENTH: These sections provide for an "**initial enrollment period**" of time when eligible residents of the United States become 65 years of age. The specific section is subparagraph (d) of Section 1395 p. It establishes a seven-month long window of opportunity wherein eligible individuals may enroll in Medicare. This **initial enrollment period** begins three months before an individual attains age 65, and ends seven months later, and enrollment eligibility continues throughout that entire period of time.

FOURTEENTH: The provisions of Federal laws also govern entitlement to Medicare benefits (Medicare B only). The pertinent United States Code sections are: Title 42, United States Code, Section 1395 q. True copies of thee sections are annexed hereto, made a part hereof, and marked Exhibit (4).

FIFTEENTH: Exhibit (4) specifies when entitlement to benefits commences. As appears from the text of Section 1395 q. the date when entitlement to benefits under Medicare B

commences varies in relation to the date of enrollment. If an individual enrolls at anytime in the first three months of this **initial enrollment period**, entitlement begins on the first day of the 4th month; if he enrolls in the 4th month, the first day of the 5th month; if he enrolls in the 5th month, the first day of the sixth month; but if he enrolls in the sixth or seventh month, then enrollment does not begin until the 1st day of the third month after the month of enrollment. Accordingly, the obvious conclusion is that eligibility for enrollment, and entitlement to benefits, are not contemporaneous events in respect to Medicare B benefits under Federal laws.

SIXTEENTH: None of the NYSHIP information booklets which the defendants, Metropolitan Life Insurance Co. or New York State Department of Civil Service, provide to *vestees* mentions these differences in time between enrollment, eligibility and entitlement, and none advises that a seven-month long **initial enrollment period** exists, nor that entitlement varies in time significantly depending upon when, during the **initial enrollment period**, an eligible individual actually applies for Medicare. It is obvious from the statute that coverage

(entitlement) can begin as late as six months after the month in which an individual has had his 65th birthday, and first becomes eligible, or as early as the first day of that month, depending upon the time of enrollment. This exposes *vestees* to the potential risk of a medical health insurance coverage gap of six months' duration if a Medicare eligible *vestee* enrolls in the sixth or seventh month of his **initial enrollment period**; especially if the NYSHIP contract determines that Medicare B benefits coverage begins on the first day of the month the *vestee* becomes eligible because he has turned 65 years of age, thus voiding his NYSHIP medical health insurance coverage for whatever Medicare pays, BEFORE his Medicare has gone into effect. Yet no such putative coverage gap is described in the information booklet, nor is notice of such a gap sent to any *vestee* at or near the time of his 65th birthday.

SEVENTEETH: Plaintiff, whose date of birth is April 18, 1932, enrolled in Medicare at age 65, in July, 1997, during the seventh month of his **initial enrollment period**. Accordingly, his entitlement to Medicare B benefits did not commence, under the federal statute, until October 1, 1997, a

full six-month delay from April 1997, the month in which plaintiff became 65 years of age, and became eligible for entitlement to Medicare benefits.

EIGHTEENTH: On August 4, 1997, during the six-month period between his month of birth (April) and his month of first entitlement to Medicare B benefits (October), plaintiff was diagnosed with rectal carcinoma. For the next six weeks, plaintiff received medical and surgical services from a variety of doctors: internists, gastro-enterologists, radiologists, anesthesiologists, and surgeons, all of whose services constituted Medicare B type services.

NINETEENTH: Upon plaintiff's and the doctors' applications for payment of these medical bills through NYSHIP, the defendant, Metropolitan Life Insurance Co., by its agent, United Health Care Services Corporation, refused to pay. These defendants advised that, according to the New York State Department of Civil Service, co-defendant herein, Medicare B was liable to pay the bills as the plaintiff's primary insurer, since plaintiff had turned 65 years of age in April, 1997.

TWENTIETH: Plaintiff then communicated with the

defendant, New York Department of Civil Service, and advised them that his enrollment in Medicare B occurred during his **initial enrollment period** which Federal law authorizes, but in the seventh month of that period. Accordingly, Medicare B entitlement to benefits did not commence until October 1st, 1997; therefore, medical service rendered in August and September 1997, were not rendered during a Medicare B entitlement period of coverage, and thus Medicare did not have to pay these bills. The defendant, Department of Civil Service, replied in a letter dated 10/16/97 that, since plaintiff had not enrolled in Medicare B "in a timely manner" as the booklet instructed him, the Empire Plan a not obligated to pay the bills.[1] A true copy of this October 16, 1997 letter from defendant, New York State Department of Civil Service, is annexed hereto, and made a part thereof, and marked Exhibit (5).

TWENTY-FIRST: Thereafter, plaintiff wrote to the defendants, Metropolitan Life Insurance Co., and United Health

---

[1] Defendant's letter cites an oblique paragraph in the booklet addressed to those who: "are no longer an active employee". In August 1997, plaintiff was working full-time for Monroe County and was making bi-weekly contributions the New York State Retirement System and was in no way inactive.

Care Services Corporation, itemizing his claims for payment of these medical bills, and demanding payment in full. These defendants replied in a letter dated November 5, 1997, that since their records showed plaintiff was eligible to enroll for Medicare benefits in April, 1997, and had not enrolled, defendants were required, under the plan, to reject any medical expenses incurred after April 1, 1997, for which Medicare B would have paid. A true copy of the defendants' letter of November 5, 1997 is annexed hereto, made a part hereof, and marked Exhibit (6).

TWENTY-SECOND: More than 60 days have elapsed since the denial of these claims of plaintiff, and these denials of payment have continued to the date of this complaint.

b. First Cause of Action

(1) State Law Claims

TWENTY-THIRD: Defendants, New York State Department of Civil Service, Metropolitan Life Insurance Co., and United Health Care Services Corporation have failed adequately to perform a duty enjoined upon them by statute, and by administrative rule, and by the standard of care the common law demands. Section 162, subparagraph 5, of the Civil Service

Law requires the defendant Department of Civil Service, to give each *vestee* a certificate "summarizing the provisions of the contract: "principally affecting the employee and his dependents." Rule 73.4 of the Rules and Regulations of the Department of Civil Service require the employer to: "prepare and distribute . . . certificates, and such other materials as may be required in connection with the administration of the plan." Under Article XI of the group insurance policy (contract No. 30500G), the Department of Civil Service has attempted to delegate its statutory duty in this regard to defendant, Metropolitan Life Insurance Co.

TWENTY-FOURTH: The certificates defendants have provided to all *vestees* pursuant to said statutory, common law, and contractual duties, utterly fail to meet the statutory standard, "principally affecting the employee", and the common law standard of reasonable care, and the standard set out in the contents of administrative Rule 73.4 because they: (1) Incorporate federal Medicare benefits enrollment eligibility as the primary insurer under the policy without adequately informing the *vestee* about his **initial enrollment period** under

federal law at the time he turns 65 years of age, and about his obligation to enroll (if there is such an obligation?) within the first three months of said **initial enrollment period**, and about the consequential loss of medical insurance coverage if the *vestee* enrolls in Medicare B in any of the last four (4) months of said **initial enrollment period**. (2) Depend upon detailed provisions of the United States Code differentiating between eligibility, enrollment, and entitlement to benefits which are nowhere mentioned or referenced in the certificates; and (3) fail to provide for a specific notice, before the vestee's 65th birthday, to the *vestee*, at his last known address, that under the pertinent provisions of the United States Code, and the variations between enrollment and entitlement contained therein, that the *vestee* must enroll between the ages of 64 years 9 months, and the month in which he attains 65 years of age, or suffer a gap in his medical insurance coverage of up to six months duration. And plaintiff alleges he received no such notice at any time.

(2) Federal Law Claims

TWENTY-FIFTH: The provisions of Title 42 Section 1395 p and Section 1395 q are the "supreme law of the land,"

and no state laws to the contrary can prevail over them. Accordingly, New York laws which purport to authorize group health insurance contracts which attempt to constrict the length of the "**initial enrollment period**," or to otherwise modify and/or alter the rights conferred under the Medicare statutes to eligible citizens when they attain 65 years of age are incompetent to do so. Only the Congress of the United States has the legislative power to change the term of the **initial enrollment period**, and group health insurance contracts - creatures of State Law - cannot both incorporate the Medicare laws as a primary insurer for group members when they become eligible and then attempt to change the terms and conditions of such Medicare laws, without Congressional consent.

FOR A SECOND, SEPARATE AND DISTINCT CAUSE OF ACTION AGAINST THE NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

TWENTY-SIXTH: Section 167-a of the Civil Service Law requires the defendant, New York State Department of Civil Service, to pay all *vestees*, when they become entitled to coverage under Medicare B, "an amount

equal to the premium charge for such supplemental medical insurance benefits, . . . monthly or at other intervals . . . from the health insurance fund."

TWENTY-SEVENTH: Plaintiff repeats and realleges, with the same force and effect as if fully set forth herein, all the allegations previously set forth in this complaint in paragraphs EIGHTH through TWENTY-SECOND.

TWENTY-EIGHTH: The defendant, Department of Civil Service, must make this premium payment to *vestees*: "upon exclusion from the coverage of the health insurance plan, the supplementary medical insurance benefits" Medicare B provides.

TWENTY-NINTH: Plaintiff alleges that the defendants, New York State Department of Civil Service, Metropolitan Life Insurance Co., and its agent, United Health Care Services Corporation, contend that plaintiff was excluded from coverage Medicare B would provide under the terms of NYSHIP on April 1st, 1997. Accordingly, payment of Medicare premiums to the Plaintiff had to begin on that day. The state's payment of the Medicare B premium is, by la, a condition

precedent to such exclusion from medical coverage under NYSHIP. Nonetheless, defendant New York State Department of Civil Service has not paid plaintiff an "amount equal to the premium charge" for Medicare B, since April 1, 1997. Accordingly, plaintiff's coverage and the coverage of all *vestees* similarly situated under NYSHIP, should continue in force meanwhile.

THIRTIETH: Attached hereto and made a part hereof, and marked Exhibit (7), is a letter from defendant, New York Department of Civil Service, dated November 20, 1997, which purports to contradict plaintiff's allegations in the preceding four paragraphs and to assert payment has been made by the New York State Department of Civil Service.

The statute, Section 167-a, reads, in part as follows:

> "Where appropriate, such amount may be deducted from contributions payable by the employee; . . ."

Certainly the group insurance premium contributions ultimately payable to defendant, Metropolitan Life Insurance Co., must diminish for those certificate beneficiaries whose

primary medical and hospital insurer has become Medicare, as compared to those group certificate beneficiaries whose primary insurer remains Metropolitan. In the latter case, Metropolitan is fully exposed to pay for all the group members' medical expenses. In the former case, however, when Medicare is the primary insurer, Metropolitan's exposure is solely to pay the difference between what Medicare pays (usually 80-85%) and what is the full sum due. Notwithstanding this obvious difference in insurance risk and coverage, defendant, New York State Department of Civil Service, maintains in its letter that group premium contributions to Metropolitan for all *vestees* remains the same regardless of whether a beneficiary's primary insurer is Medicare. Accordingly, defendant states that, when a Medicare covered beneficiary begins to pay his Medicare B premium, he still must also continue to pay, in addition a full premium contribution to Metropolitan. The defendant then, in conformity with the authorization set forth in the statutes, deducts the Medicare B premium payment from to the beneficiary's account obligation with Metropolitan, and either bills the *vestee* only for the difference, or remits to the *vestee*

the surplus. Plaintiff cannot believe these assertions in Exhibit (7) because they defy common sense.

In any event, defendant, New York State Department of Civil Service, has sent plaintiff two checks (for $18.00 each); one in August, 1997, and one in November, claiming that these sums represent the surplus between what plaintiff has paid to Medicare B and what plaintiff owed to Metropolitan. In fact, plaintiff has paid but one Medicare B premium, due in September 1997, for the last calendar quarter of 1997; and has meanwhile tendered premium payments to defendants for the April-October months, but defendants have rejected such tender. In any event, if what defendant, New York State Department of Civil Service, says is true, defendant has paid Metropolitan Life Insurance Co. its full premiums for the period, April - October 1997, and plaintiff should therefore have medical coverage under the group policy.

FOR A THIRD SEPARATE AND DISTINCT CAUSE OF ACTION AGAINST DEFENDANT NEW YORKI STATEDEPARTMENT OF CIVIL SERVICE, METROPOLITAN LIFE INSURANCE CO., AND UNITED HEALTH CARE SERVICES CORPORATION

THIRTY-FIRST: Plaintiff repeats and realleges with the same force and effect as if fully set forth herein all the allegations previously set forth in this complaint in paragraphs EIGHTH through TWENTY-SECOND.

THIRTY-SECOND: The above-named defendants have failed to perform a duty imposed upon them under the terms of the Group Insurance Policy 30,500 G, dated January 1", 1986, as to which policy terms the plaintiff and all *vestees* similarly situated are third-party beneficiaries.

THIRTY-THIRD: The defendants have agreed among themselves in Exhibit (7) to said contract, which is attached hereto, and made a part hereof, and marked Exhibit (8), to an Empire Plan Communications Program. The main purpose of said plan is to "advise employees of the plan's benefits and features," and to assure that its administrators "have adequate information to administer the program

properly."

THIRTY-FOURTH: In regard to the obligation which the defendants are currently attempting to impose on plaintiff, and on all *vestees* similarly situated, to enroll in Medicare B no later than the first three months of the seven-month **initial enrollment period**, which Federal law has granted to eligible Medicare beneficiaries, the defendants have breached their contractual duty to advise employees of the plan's features because: (1) the information booklets which they provide do not contain this specific information, and (2) the defendants have no program or policy to notify *vestees*, before they turn 65 years of age, that Medicare enrollment and Medicare B entitlement varies with the time of enrollment, and if *vestee* beneficiaries enroll in any of the last four (4) months of their **initial enrollment period**, they shall suffer a gap in medical insurance coverage, which could extend for a period of up to six months, and (3) no administrators of the plan have been told this information to pass on to *vestees*.

FOR A FOURTH, SEPARATE AND DISTINCT CAUSE OF ACTION AGAINST DEFENDANTS, NEW YORI STATE DEPARTMENT OF CIVIL SERVICE, METROPOLITAN LIFE INSURANCE CO., ANDUNITED HEALTH CARE SERVICES CORPORATION

THIRTY-FIFTH: Plaintiff repeats and re-alleges with the same force and effect as if fully set forth herein all the allegations previously set forth in this complaint in paragraphs EIGHTH through TWENTY-SECOND.

THIRTY-SIXTH: The defendants have failed to perform a duty imposed upon them under the provisions of the United States Code: to with the provisions of subchapter XX of Title 42 U.S.C. Section 300 bb - 1 through Section 300 bb-8, which require state governmental group health plans to grant continuation medical insurance coverage to qualified beneficiaries.

THIRTY-SEVENTH: All *vestees*, as hereinabove described and including plaintiff, become qualified beneficiaries under the Act as soon as they terminate their employment with the State under honorable conditions. See Section 300 bb-8, subparagraph (3)(B) of Title 42 of the United States Code.

THIRTY-EIGHTH: Continuation of Group health plan coverage for qualified beneficiaries must extend for a period which begins on the date of the qualifying event (in this case termination), and ending not earlier than:

> (II) the date on which the qualified beneficiary first becomes, after the date of election
> (i) ...
> (ii) entitled to benefits under Title XVIII of the Social Security Act (42 U.S.C. Section 1395, et seq.),

See Title 42 U.S.C. Section 300 bb-2, subparagraph (2) (D).

THIRTY-NINTH: The plaintiff became entitled to benefits under Title XVIII of the Social Security Act on October 1st, 1997, and, since plaintiff was in a governmental group health plan, his coverage under that NYSHIP plan, according to the federal statute, could not end until his entitlement to benefits under Medicare B had begun.

FORTIETH: Accordingly, the NYSHIP plan, even if the Court finds that the group contract authorizes termination of coverage when *vestees* have merely a right to enroll in Medicare, not even when they have a contact duty to enroll,

because such governmental group plan medical insurance coverage must continue to the date of entitlement to benefits in order to comply with federal laws. These federal laws override any NHSHIP contract provision to the contrary.

FORTH-FIRST: Moreover, Title 42 U.S.C. Section 300 bb-6 obligates the defendants, New York State Department of Civil Service, Metropolitan Life Insurance Co. and United Health Care Services Corporation, to notify *vestees*, and their dependents - at the time of commencement of coverage under the group health insurance plan - in writing, of their rights under the federal statute. The defendants have not given plaintiff, as *vestee*, or any other *vestee* similarly situated, written notice that group medical insurance can end only when the *vestee* becomes "entitled to benefits under Title XVIII of the Social Security Act" (42 U.S.C. 1395, et seq.) according to federal law.

FOR A FIFTH, SEPARATE AND DISTINCT CAUSE OF ACTION AGAINST DEFENDANT WILLIAM J. BROREIN, M.D., PLAINTIFF ON HIS SOLE BEHALF, ALLEGES:

FORTY-SECOND: Plaintiff repeats and realleges

with the same force and effect as if fully set forth herein all the allegations previously set forth in this complaint in paragraphs EIGHTH through TWENTY-FIRST.

FORTY-THIRD: Defendant BROREIN was plaintiff's personal physician for about ten (10) years prior to August, 1997. In that capacity, the defendant conducted a complete physical examination of plaintiff on April 17, 1997, the day before plaintiff's 65th birthday.

FORTY-FOURTH: Plaintiff alleges that at the time of this examination he had a bleeding rectal tumor. Plaintiff notified the defendant of his symptoms of rectal bleeding during the examination.

FORTY-FIFTH: Defendant, notwithstanding his knowledge of the symptoms, and is conduct of the physical examination, failed to detect the existence of the tumor, failed to order proper diagnostic tests consistent with the symptomology, and failed to refer the plaintiff to a proper specialist. These omissions constitute medical malpractice as a matter of law, and the certificate required by C.P.L.R. Section 3013-a is attached to this Complaint as Exhibit (9).

FORTH-SIXTH: Plaintiff alleges he is a qualified "party" under C.P.L.R. Section 8602(d) and intends to make application for reasonable counsel fees against the State under Article 86 of the C.P.L.R. and under Article 9 of the C.P.L.R., Section 909.

WHEREFORE, Plaintiff, as *vestee*, for himself, and for all other *vestees* similarly situated, demands Judgment as follows:

1) **On the First Cause of Action:**

(a) A declaratory judgment under C.P.L.R. Section 3001 that the certificates and information booklet provided *vestees* pursuant to the cited statutes, rules and the common law, do not adequately or sufficiently summarize the provisions of the group health insurance contract which principally affect the *vestees* and their dependents because: they do not inform *vestees* that enrollment in the last four months of said period may result in a gap in group health insurance medical coverage; and do not provide for a specific notice to each *vestee* at the time he approaches 65 years of age of these features of the group policy which may adversely affect him, and further

(b) A mandatory injunction against the named defendants requiring them to put this sort of information in their booklet, and to advise their administrators of these features of the group medical policy affecting *vestees* and to issue such notices to *vestees* as above described at the earliest practicable time.

(c) A judgment declaring the state statutes, and the group health contract provisions they authorize, which shorten and constrict the federal Medicare **initial enrollment period** under Section 1395 p and q of Title 42 of the United States Code unconstitutional and void.

(2) **On the Second Cause of Action:**

A declaratory judgment that the defendant, New York State Department of Civil Service, has violated the provisions of Section 167-a of the Civil Service Law because the Department has failed to pay to plaintiff and all other *vestees* similarly situated the premiums they pay for Medicare B benefits, which is a condition precedent for excluding those supplemental Medicare B benefits from the coverage of the group insurance policy and for making Medicare the primary health insurer, and

further a declaratory judgment that *vestees* who pay Medicare B premiums in order to establish Medicare as their primary health insurer do not have an obligation to continue to pay the State the full contract sum premium due under the group health insurance policy, and that, therefore, the credit the defendant, New York State Department of Civil Service, takes for such group health policy premium payment is inappropriate under the statute; and the State must accordingly pay *vestees* the full Medicare premium they pay to Medicare, without the benefit of such deduction, and

(b) A mandatory injunction directing such payment of Medicare B premiums to all *vestees*, as the statute requires, for the past six years.

(3) **On the Third Cause of Action:**

(a) A declaratory judgment that the defendants have breached the terms of the group insurance contract which requires the defendants to advise employees of the plan's benefits and features because they have not advised *vestees* sufficiently and adequately of that feature of the group insurance policy which puts *vestees* at risk of losing group medical

insurance benefits coverage for a period of up to sic months in the event they enroll in Medicare B during the last four months of their federal **initial enrollment period**. (Title 42 U.S.C. 1395 p), and because they have failed to inform their staff and administrators of this potential gap in group health medical insurance coverage, and

(b) For a mandatory injunction requiring the defendants to inform *vestees* and their staff and administrators, accordingly, pursuant to the provision of the group contract.

(4) **On the Fourth Cause of Action:**

(a) A declaratory judgment that the group insurance policy, 30,500G, insofar as it may provide that its medical insurance coverage ceases when *vestees* become 65 years of age and eligible to enroll in Medicare B regardless of whether, at that time, such *vestees* are entitled to Medicare B benefits, violates the provision of federal law, 42 U.S.C. Section 300 bb-1,through 300 bb-8, because such group medical insurance can only upon entitlement and not upon eligibility to enroll, and further, that the failure to so notify *vestees* in writing at the time of the commencement of coverage violates Section 300 bb-6 of

said statute, and a further declaratory judgment that group medical coverage must continue for such *vestees* until they have entitlement to Medicare B benefits, and

(b) A mandatory injunction directing the defendants to provide continuous coverage of medical insurance benefits under the state's group health policy until the day entitlement to Medicare B benefits begins for such *vestees*, and an injunction requiring defendants to give *vestees* notice to that effect.

(5) **On all of the first four causes of action as incidental relief to the plaintiff, individually, and not as class action relief:**

An Order directing the defendants, New York State Department of Civil Service, Metropolitan Life Insurance Co., and United Health Care Services Corporation to pay in full, with interest form the accrued date due to the date of payment, the medical expenses plaintiff has incurred during August and September, 1997, in connection with his above-described illness; and an Order authorizing the entry of a judgment against those defendants for the full amount so payable, together with the costs, disbursements, and attorney's fees, incurred in this action.

(6) **On the Fifth Cause of Action:**

(a) Judgment against the defendant in the sum of Two Hundred Fifty Thousand Dollars or such larger sum as shall adequately compensate the plaintiff for his injuries and damages.

All of which the plaintiff demands together with the costs, disbursements, and attorneys' fees incurred in the prosecution of this action.

Yours, etc.

REGAN & REGAN, P.C.
BY: JAMES A. ROBINSON, ESQ., Of Counsel
13 South Fitzhugh Street
Rochester, New York 14614

DATED: December 30, 1997

VERIFICATION

STATE OF NEW YORK :
COUNTY OF MONROE : ss.:

I, JOHN MANNING REGAN, being duly sworn, do hereby depose and say that:

I am the plaintiff in the within action; I have read the foregoing Complaint and know the contents thereof; the contents of the Complaint are true to my knowledge, except as to those matters alleged o be upon information and belief, and as to those matters, I believe them to be true.

s/ John Manning Regan
JOHN MANNING REGAN

Sworn to before me this
30th day of December, 1997.

S/ Barbara Ann Lohouse
Notary Public
Comm. Expires 9/30/99

TEXT FROM EXHIBIT (1) TO COMPLAINT

You and your dependents must enroll when eligible for primary Medicare coverage	When you or your covered dependent becomes eligible for primary Medicare coverage, you or your covered dependent must enroll in Medicare Parts A and B. If you do not, your benefits under the Empire Plan or your HMO will be drastically reduced. Empire Plan Enrollees: the Empire Plan will not provide any benefits for coverage available under Medicare. If you or a dependent is eligible for primary Medicare coverage, but does not enroll. you will be responsible for the full cost of medical services that Medicare would have covered.
For all enrollees	...If you are no longer an active employee, contact your local social security office three months before you or your spouse turns age 65, to arrange for enrollment in Medicare Parts A and B. Once you or your spouse has enrolled, Medicare coverage becomes effective on the first day of the month in which you reach 65.

TEXT-FROM EXHIBIT (2) TO COMPLAINT

NYSHIP you and/or your covered dependent to enroll Medicare Parts A and B when you/they

- Are age 65 or older, or
- Regardless of age, have been classified by Social Security or disabled for more than 24 months, or
- Regardless of age, have end state renal disease (permanent kidney failure).

If you did not enroll in Medicare Parts A and B when

you were first eligible, you must sign up during the Medicare general enrollment period January 1, through March 31. Your coverage will begin on July 1. Medicare adds a premium charge for late enrollment.

The Empire Plan will not provide any benefits for services that Medicare would have paid for if you had enrolled as required.

See your NYSHIP General Information Booklet for details about Medicare and COBRA enrollment.

Note to COBRA enrollees: Your NYSHIP coverage under COBRA ends when you become eligible for Medicare.

STATE OF NEW YORK
SUPREME COURT COUNTY OF MONROE

JOHN MANNING REGAN, ON BEHALF OF HIMSELF, AND ALL OTHER VESTEES WITHIN THE NEW YORK STATE HEALTH INSURANCE PLAN, WHO ARE SIMILARLY SITUATED;
29 HOYT PLACE
ROCHESTER, NEW YORK

Plaintiff

AFFIDAVIT

v.

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE, ALBANY, N.Y.; METROPOLITAN LIFE INSURANE CO., 1 MADISON AVE., NEW YORK CITY, NEW YORK; UNITED HEALTH CARE SERVICES CORPORATION, AS ADMINISTRATOR. 505 BOICES LANE, KINGSTON, NEW YORK; AND WILLIAM J. BROREIN, M.D., 2265 South Clinton Ave., Rochester, NY 14618

Defendants.

STATE OF NEW YORK)
) SS.:
COUNTY OF ALBANY)

Christine Williams, being duly sworn, deposes and says:

1. I am employed as an Employee Benefits Representative in the Division of Employee Benefits ("the Division") in the Department of Civil Service ("the

Department") for the State of New York. I have been serving as Manager of the Policy Unit of the Division for more than six years and have been employed in the Division for over twenty years. Therefore, I am familiar with the Division's administration of the New York State Health Insurance Program ("NYSHIP") and the books and records related to NYSHIP. Further, I am responsible for NYSHIP's compliance with State and federal requirements, including the federal Medicare program. I submit this Affidavit in support of Defendant's Motion for Summary Judgment. The facts set forth in this affidavit are based upon my personal knowledge of NYSHIP as Manager of the Policy Unit and the Division's Records.

2. NYSHIP is administered by the Department under Civil Service Law, Article XI, in compliance with State and federal laws and regulations governing the coordination of benefits for NYSHIP enrollees who are eligible for both NYSHIP coverage and Medicare. Under Civil Service Law, section 162 the President of the Civil Service Commission is authorized to purchase contracts for benefits provided under NYSHIP from insurance companies.

3. NYSHIP provides medical benefits for enrollees and their eligible dependents through two different options; the Empire Plan, a comprehensive health insurance plan, or one of several health maintenance organizations in the enrollee's specific geographic area. Plaintiff chose to enroll voluntarily in the Empire Plan. As one insurer under the Empire Plan option of the NYSHIP, Metropolitan Life Insurance Company through its administrator, United Health Care Corp., provides coverage for doctors' visits and other medical services. Enrollees are required to pay a proportionate share of their premiums as required by the Civil Service Law.

4. The terms of coverage provided under the Empire Plan are set forth in a publication entitled "General Information Book and Empire Plan Certificate". In plaintiff's case, the booklet entitled "General Information Book and Empire Plan Certificate for Retirees, Vestees, Dependent Survivors and Enrollees covered under Preferred List Provisions of New York State Government and Participating Employers, and their enrolled dependent and for COBRA enrollees", governs his coverage under the Empire Plan (hereinafter the Plan Booklet,

attached hereto as Exhibit A).

5. Under the express terms of the Empire Plan, when an enrollee becomes eligible for primary Medicare coverage, the enrollee "**must enroll in Medicare Parts A and B. If you do not, your benefits under the Empire Plan or your HMO will be drastically reduced.**" (emphasis in original).[1] The Plan Booklet further informs Empire Plan enrollees that the "Empire Plan will not provide any benefits for coverage available under Medicare. If you or a dependent is eligible for primary Medicare coverage, but does not enroll you will be responsible for the full cost of medical services that Medicare would have covered." (See Exhibit A at 23.)

6. The Plan Booklet states that a :"health insurance plan provides 'primary coverage' when it is responsible for paying health benefits before any other group health insurance is liable for payment." (See Exhibit A at 23.) Medicare was

---

[1] Medicare has two parts: Part A is hospital insurance which pays for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care. Part B is medical insurance which pays for medically necessary doctors' services, outpatient hospital services, home health services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

7. introduced in 1965 as part of Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled" and commonly referred to as the "Medicare". Medicare is divided into two parts: Part A for hospitalization costs and Part B for basic medical care. Participation is contingent on participation in Social Security. Originally, the program covered all eligible individuals over age 65, and Medicare paid claims as the primary insurer for all Medicare beneficiaries; employer-sponsored group health insurance programs under which the Medicare-eligible individual was also covered based their payments on what remained unpaid by Medicare. However, through the years, Medicare has been restructured by various federal laws to make Medicare the secondary payer - that is - Medicare pays benefits after another insurer pays benefits first, for Medicare eligible persons who are covered as active employees under employer-sponsored group health plans (GHP) such as NYSHIP. At the present time, GHPs are responsible for primary coverage for all persons covered under the GHP as active employees or as the dependents of active employees. However, Medicare continues

to pay primary benefits only for persons who are covered under employer's health plan but are not active employees, such as retirees like Mr. Regan or vestees. The Health Care Financing Administration calls enforcement of the Medicare secondary provision of the Social Security Act the Medicare Secondary Payer program (MSP).

8. The federal statutory authority for the way in which Medicare and NYSHIP, as a GHP, coordinate, is Section 1862(b)(1)(A) of the Social Security Act, which states that Medicare is the secondary payer for services for which a Medicare beneficiary, age 65 or older, would receive payment under an employer group health plan which covers the person by virtue of that person's current employment status. Federal regulations 42 Code of Federal Regulations (CFR) Parts 400 and 411, provide guidance for MSP administration. 42 CFR Section 411.172 states in pertinent part:

> Section 411.172, Medicare benefits secondary to group health plan benefits.
>
> (a) Conditions that the individual must meet. Medicare Part A and B benefits are secondary to benefits payable by a GHP for service furnished during any

month in which the individual -

(1) Is aged (65 or over);

(2) Is entitled to Medicare part A benefits under Section 406.10 of this chapter; and

(3) Meets one of the following conditions:

(i) Is covered under a GHP of an employer that has at least 20 employees (including a multi-employer plan in which at least one of the participating employers meets that condition), and **coverage under the plan is by virtue of the individual's current employment status.** (emphasis added)

Consequently, since Mr. Regan's coverage in NYSHIP is not by virtue of having current employment status with the State of New York, but, rather, as a former employee, Medicare, not NYSHIP, is the primary insurer for Mr. Regan.

9. NYSHIP is administered to ensure that enrolled individuals are given notice as to how to proceed so that their primary Medicare coverage is in place as of the date when their

NYSHIP coverage becomes secondary to Medicare, which is the first day of the month of their 65th birthday if they are retired when they turn 65.

10. In accordance with the MSP rules, the date on which NYSHIP coverage becomes secondary is different if the enrolling person is still an active employee of New York State or one of NYSHIP's participating agencies at the time of his/her 65th birthday. However, this is not the situation in Mr. Regan's case, since Mr. Regan was retired from his employment with the State at the time of his 65th birthday. Even though he may have been an active employee of another employer, his status for MSP purposes is dependent on his employment status with the employer that sponsors the benefit plan through which his health insurance is provided, which, in this case, is the State of New York.

11. Under NYSHIP, i.e., for purposes of determining whether Medicare coverage is the primary insurance, there is no distinction between a "Vestee" and a "Retiree," since both are non-active employee enrollees.

12. I advised Plaintiff of this fact by letter dated

November 20, 1997. (A copy of my letter, dated November 20, 1997, is attached hereto as "Exhibit B.")

13. Civil Service Law, Section 163(3) is applicable to the categorization of Mr. Regan as a "retiree" for NYSHIP purposes. Mr. Regan was entitled to begin receipt of his pension, having satisfied the age and pension requirements upon his leaving employment with New York State. A vested enrollee under NYSHIP becomes a retiree at the age of 55, when that enrollee becomes eligible to receive his or her pension. The regulatory definition of vestee no longer applies after age 55. Therefore, under the operation of NYSHIP, Mr. Regan, who is 65 years of age and eligible for retirement becomes a "constructive: retiree entitled to receive the employer's contribution toward the NYSHP premium, regardless of the fact that he was not actually retired for pension receipt purposes.

14. Indeed, under the express terms of NYSHIP, an enrollee "may retire for health insurance purposes, even if you delay collecting your pension." (See Exhibit A at 4.) Mr. Regan recognized as much in a letter to the Department wherein

his attorney stated that "Mr. Regan retired for the purposes of health insurance only, in 1992 at the age of 60", but had not yet retired for the receipt of any other retirement benefits. (A copy of Mr. Regan, Jr.'s. letter, dated September 18, 1997, is attached hereto as Exhibit C.)

15. In fact, Mr. Regan agree with his characterization as a "Retiree" when he returned the 1997 NYSHIP Benefit Statement Correction form showing his status as "Retired". Mr. Regan, in the form send by the Employee Benefit Division, was given the option of changing incorrect information. Mr. Regan returned the form to the Department unchanged with respect to his categorization as "Retired." (See Exhibit D attached hereto.) Further, Mr. Regan in his letter of July 22, 1997 requested the Employee Benefits Division of NYSHIP "provide me with the terms and conditions of the plan after **a retiree** (emphasis added) has reached 65." (See Gary Teeple affidavit, Exhibit A.)

16. Even for active employees, NYSHIP requires that, upon retirement, they must make sure that Medicare is effective at the earliest possible date under the Medicare "special

enrollment period" rules by applying for Medicare prior to the date their NYSHIP coverage becomes secondary.

17. For individuals receiving Social Security payments, enrollment in Medicare is automatic, with coverage becoming effective on the first day of the month in which the 65th birthday occurs. For individuals who are not receiving Social Security current Medicare publication No. 05-10043, published by the Social Security Administration, August, 1995, advises individuals to "contact u about three months before your 65th birthday to sign up for Medicare." This is the same advice given to NYSHIP enrollees in numerous NYSHIP publications provided to enrollees in order to enable them to have Medicare in effect on the earliest possible date to avoid a loss of insurance benefits. (See Caroline Sever affidavit, ¶. 9.)

18. Indeed, the Plan Booklet explicitly states that:

> "If you are no longer an active employee, contact your Social Security Office three months before you or your spouse turns age 65 to arrange for enrollment in Medicare Parts A and B. Once you or your spouse has

> enrolled, Medicare coverage becomes effective on the first day of the month in which you reach age 65." (See Exhibit A at 24).

As Mr. Regan's counsel conceded, "in April 1997, Mr. Regan turned 65 years of age and became eligible for Medicare coverage." (See Exhibit C.)

19. The following instructions provided in the Booklet clearly notify enrollees of the result that will occur if enrollees do not enroll in Medicare:

> "When you or your covered dependent becomes eligible for primary Medicare coverage, you or your covered dependent must enroll in Medicare parts A and B. If you do not, your benefits under the Empire Plan or your HMO will be drastically reduced." (See Exhibit A at 24.)

19. The notification is further reinforced in the Metropolitan Certificate of Insurance which is part of the General Information Booklet in a section entitled "Impact of Medicare on this Plan", as follows:

> "When you are eligible for primary coverage under

Medicare, the benefits under this Plan will change.

"Please refer to the General Information section of this book for information on when you must enroll for Medicare and when Medicare becomes your primary coverage. If you or your dependent is eligible for primary Medicare coverage - even if you our your dependent fails to enroll - your covered medical expenses will be reduced by the amount available under Medicare, and Metropolitan will consider the balance for payment, subject to copayment deductible and coinsurance.

"A. Retired Employees and/or their Dependents -- If you or they are eligible for primary coverage under Medicare -- even if you or they fail to enroll - your covered medical expenses will be reduced by the amount that would have been aid by Medicare, and Metropolitan will consider the balance for payment, subject to copayment, deducible and coinsurance." (See Exhibit A, at 76-77.)

20. Medicare Part B is medical insurance, which pays for such things as doctors' services, home health service, and

other medical services and supplies that are not covered by Part A. Medicare Part B requires payment of a monthly premium and, therefore, can be declined by individuals who do not want to enroll in it because it requires such payment. However, **under NYSHIP rules**, those who are eligible for Medicare Part BMUST enroll to avoid reduced health insurance coverage, because NYSHIP benefits become secondary based on an individual's **eligibility** for Medicare Part B, **not** their actual **enrollment** in it.

21. For this reason, Civil Service Law, Section 167-a, mandates that the Medicare eligible NYSHIP enrollee, such as Mr. Regan, be reimbursed for the cost of Medicare Part B premium. Reimbursement is provided as of the first possible eligibility date, regardless of whether or when an individual enrolls in Medicare Part B, and NYSHIP benefits become secondary as of that date. When the federal Medicare program became available in 1966, the New York State Legislature amended the Civil Service Law to include section 167-a, which provides the authorization for NYSHIP to become secondary when an enrollee "is or would be eligible" for Medicare, which

is the first day of the month of the enrollee's 65th birthday. Based on this statutory authorization in Civil Service law section 167-a, NYSHIP assumes a secondary position and reimburses enrollees as of the first possible date of their entitlement to Medicare, comparable to other employers nationwide. This NYSHIP design under Civil Service Law, section 167-a came as a result of the federal Medicare program and was implemented to be consistent with the Medicare program.

22. Individuals who fail to enroll in Medicare as soon as they are eligible to do so, are still reimbursed for the Part B premium and become responsible for any medical expenses not covered by Medicare due to such failure to enroll.

23. This is what occurred as a result of Mr. Regan's failure to follow the NYSHIP requirement regarding enrolling in Medicare.

24. The federal Medicare enrollment rules provide for variable effective dates for those who enroll in Medicare Part B during their initial enrollment period. The NYSHIP requirements for continuation of NYSHIP benefits as secondary do not change the federal Medicare rules.

25. The initial enrollment period is defined by the federal rules as the seven-month period of time beginning three months prior to the month following the month in which the 65th birthday occurs. The Social Security Administration advised individuals who are eligible for Medicare of this seven month period in its "Medicare" brochure, SSA Publication No. 05-10043, August, 1995. (Attached hereto as Exhibit E, is a copy of pp. 7-8 of such Brochure.)

26. The first day of the month in which the 65th birthday occurs is the earliest possible effective date for Medicare Part B coverage for the individual. Medicare Part B can become effective on the date only if the individual applies for Medicare Part B prior to that day; in other words, during the three months immediately preceding that date. This is because an individual cannot have Medicare coverage until AFTER application for Medicare is made.

27. A person who does not apply prior to the birth month gets a delayed effective date, which varies depending on when the application is filed during the last four months of the initial enrollment period. If the application is filed during the

birth month, or during the fifth or sixth month of the initial enrollment period, the coverage actually begins on the first day of the month next following the month in which the application was made.

28. If the application is made in the seventh or last month of the initial enrollment period, coverage does not start until the first day of the third month following the application month, or six months from the first date on which Medicare coverage was available if the earliest possible application had been made.

29. It appears that Mr. Regan waited to apply for Medicare until the seventh month of his initial enrollment period; therefore, his Medicare coverage did not start until the first day of the third month after his application.

30. The NYSHP option known as the Empire Plan, in which Mr. Regan is enrolled, is a fully insured, experience-rated group insurance program. Since the beginning of the federal Medicare Program in 1967, the NYSHIP underwriting control assumptions for the Empire Plan have included an assumption that NYSHIP will become secondary payor to Medicare as of the

first possible Medicare effective date a NYSHIP enrollee can have under the federal rules, which is, as explained above, the first day of the month in which the 65th birthday occurs.

31. Consistent with the statutory mandate in Civil Service Law, Section 161(3), the President is required to design a NYSHIP plan that includes reasonable underwriting controls and provides reasonable assurance of stability in the future for the benefit of all enrollees, active and retired. For underwriting assumptions to be accurate, variables must be held to a minimum. Therefore, NYSHIP requirements are designed to reduce the number of variables in the underwriting assumptions.

32. Granting primary coverage to an individual who is plan-secondary in the underwriting assumptions increases actual Plan claims costs above predicted costs to the economic detriment of all other enrollees. This is why a specific effective date for the transfer of NYSHIP liability from primary to secondary has been established and repeatedly communicated to NYSHIP enrollees by means of publications sent by the Division's Communications Unit as further set forth in Caroline Sever's affidavit in support of defendants' Motion for Summary

Judgment.

33. This assumption is an important factor in keeping premium costs as low as possible for the entire NYSHIP enrolled population of over 800,000 individuals because premiums for an experience-rated plan are based on the cost of claims paid by the insurers. Obviously, any claims that must first be considered and paid by another insurer such as Medicare, do not have to be paid by NYSHIP. The covered expense under NYSHP is reduced to the remaining unpaid balance after the first insurer has paid benefits.

34. By providing NYSHIP enrollees with reimbursement of the cost of purchasing primary coverage from Medicare, and advising all enrollees of the resulting loss of coverage for failure to follow the NYSHP requirements, NYSHP absolves itself of responsibility for those costs, which Medicare insures.

35. In requesting relief in the form of reimbursement of medical expenses, Mr. Regan is asking that NYSHP be required to pay claims that Medicare would have paid had he followed the NYSHIP requirements.

36. As set forth above, the federal Medicare Enrollment rules provide for variable effective dates depending on when the application is filed. When making underwriting assumptions, it is important to eliminate as much variability as possible regarding the claims for which NYSHP will be responsible. Therefore, NYSHIP rules have always required that any NYSHIP enrollee who is eligible for primary Medicare PART B benefits apply for those benefits in a manner, which allows the Medicare coverage to begin on THE EARLIEST POSSIBLE EFFECTIVE DATE under the Medicare rules. NYSHIP enrollees are repeatedly advised to apply for Medicare coverage THREE MONTHS BEFORE the month in which their 65th birthday occurs, so that the Medicare coverage will start on the day that NYSHIP underwriting assumptions presume that it will.

37. Based on the assumption that Medicare will become primary coverage for NYSHP enrollees on the first day of the month of the 65th birthday and, that NYSHIP enrollees will follow the NYSHIP directions to apply for Medicare three months prior to that month so that it actually does begin on that date, NYSHIP insurers, such as Metropolitan Life Insurance

Co., are instructed to begin excluding primary coverage for all expenses that are covered under Medicare Part B as of the first day of the month during which the enrollee becomes 65. Mr. Regan's medical expenses for the period in question have been considered and paid on that basis pursuant to the express terms of NYSHIP.

38. Based on the requirements of Civil Service Law, Section 167-a, NYSHIP begins reimbursing individuals, such as Mr. Regan, who are excluded from primary NYSHIP benefits for the cost of their enrollment in Medicare Part B as of the first day of the month of their 65th birthday. From April 1,1997 to the present, plaintiff's Medicare Part B reimbursement under Civil Service Law, section 167-a was greater than his quarterly NYSHP premium, and as a result the Department of Civil Service credits the difference to plaintiff and on a quarterly basis requests the comptroller to issue a refund check to the plaintiff. (See Exhibit F, which are four NYSHIP computer pages showing Civil Service Law, §167-a credit amounts for Mr. Regan from April 1, 1997 through June 1, 1998.) NYSHIP also returned Mr. Regan's premium payment for $112.86 as an

overpayment because his Medicare Part B reimbursement was credited to his account for the quarter beginning April 1, 1997. Thus, individuals who become eligible for primary benefits from Medicare, and secondary benefits from NYSHIP, are entitled to a combination of benefits that exceeds those of each individual program for the same cost that they previously paid for NYSHIP coverage alone. All of the enrollees of NYSHIP are advantaged by the reduced claims liability of NYSHP for the Medicare-primary enrollee.

39. An individual who does not follow NYSHIP directions to enroll in Medicare during the three months prior to their 65th birth-month will have a gap in coverage for the period of time between the earliest possible Medicare effective date (which is the first day of the birth-month) and the date Medicare coverage actually starts based on the federal enrollment rule described above, which, could be as much as 6 months after the first day of the birth-month. NYSHIP enrollees are clearly advised of this consequence if they fail to enroll as directed by NYSHIP. (See Exhibit C, pp. 23-24 and pp. 76-77). If they have a gap, they are essentially UNINSURED for any expenses

that would have been paid by Medicare Part B IF THEY HAD ENROLLED AS DIRECTED BY NYSHIP, because Medicare will not pay any expenses incurred prior to the Medicare effective date, and NYSHIP will pay only secondary benefits.

40. This is, in fact, exactly what happened in Mr. Regan's case. He did not apply for Medicare Part B until the last month of his initial enrollment period; therefore, his Medicare coverage did not become effective until the third month following his application, i.e. October 1, \1997, instead of April 1, 1997, under the Medicare enrollment rules. As explicitly detailed in over twenty publications sent to plaintiff, Mr. Regan's NYSHIP coverage became secondary as of the earliest possible Medicare effective date he could have had, that is April 1, 1997.

41. When Mr. Regan filed claims for benefits, United Healthcare as the claims administrator for Metropolitan, excluded all expenses that Medicare would have paid if he had signed up as directed by NYSHIP, and paid benefits on the balance as secondary payor. I explained this to Mr. Regan's legal representative, John Regan, Jr., in my letter of October 16,

1997. The expenses that have not been paid are those which Medicare declined to pay because his Medicare was not in effect on the date the expenses were incurred. (Attached hereto as Exhibit G is a copy of my October 16, 1997 letter.)

42. Since the plaintiff's unpaid expenses would have been paid by Medicare if he had applied as directed by NYSHIP, Mr. Regan was advised to contact Medicare for an amended effective date in my letter of October 10,1997, to his legal representative, John Regan, Jr. I do not know whether the Plaintiff or Mr. Regan, Jr. followed that advice.

43. NYSHIP enrollees are provided with a vast number of informational materials that explain the rules regarding enrollment in Medicare and other aspects of NYSHIP coverage. See Caroline Sever's affidavit in support of defendant's Motion for Summary Judgment for exhibits for NYSHIP communications material, which NYSHIP has sent over the years to active and retired State employees, including Mr. Regan.

44. In addition, NYSHIP provides toll-free telephone access to trained NYSHIP representatives who provide enrollees

with specific and consistent information on how to follow NYSHIP rules and maintain full benefits when they become eligible for primary Medicare. (See Gary Teeple affidavit in support of defendant's Motion for Summary Judgment regarding the discussion of Mr. Teeple, a NYSHIP representative, with Mr. Regan in August, 1997.)

45. NYSHIP requirements are clearly explained. In fact, Mr. Regan himself followed them correctly and without problem in 1994 when he submitted to us a written notice that his wife had enrolled in Medicare as of the first day of the month of her 65th birthday, and that he was therefore applying for reimbursement of her Medicare Part B premium. (Attached hereto as Exhibit H is Mr. Regan's Letter to the New York State Health Insurance Program, which he completed and signed.)

46. The form that Mr. Regan used to supply this information was a copy of a sample letter that is part of the Plan Booklet for retired State employees sent to Mr. Regan as one of the many notices form the NYSHIP. This is the same Plan Booklet, in which the information about ho to enroll in Medicare to avoid coverage gaps is also provided and from which Mr.

Regan excerpts material in Exhibit 1 of the complaint (See Exhibit A.)

47. Under a fully experience rated plan such as NYSHIP, granting the monetary reimbursement sought by Mr. Regan will have a damaging, detrimental and unfair impact in that it will require the other enrollees who have complied with NYSHIP requirements by enrolling in Medicare Part B in compliance with NYSHIP requirements, to pay for his failure to follow such requirements.

S/ Christine Williams

Sworn to before me this
18th day of June, 1998.

S/ Joseph R. Healy
Notary Public, State of New York
Residing in Saratoga County
Commission Expires March 30, 1999

Appendix

Statutes

(a) The Constitutional and Statutory provisions involved in the Case

1. Statutory

Title 42 U.S.C. §1395 p: *Enrollment Periods*

(a) General: regulations

> An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

(b) Repealed

(c) (Omitted) Eligible individuals before March 1, 1966

(d) Eligible individuals on or after March 1, 1966

> In the case of an individual who first satisfies paragraph 1 or 2 of § 1395 o of this title on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on the determination by the secretary of the month in which such

individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the secretary shall establish for such individual an individual enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under §1395 q of this title as though he had attained such age at that time).

Title 42 USC §1395 q: **Coverage Period**

(a) Commencement

The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) July 1, 1966 or in the case of a disabled individual who has not obtained age 65, July 1, 1973 or

(2) (A) In the case of an individual who enrolls pursuant to such subsection (d) of §1395 p of this title before the month in which he first satisfies paragraph (1) or (2) of §1395 o this title, the first day of such month, or

(B) In the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first

satisfies such paragraph, the first day of the month following the month in which he so enrolls, or

(C) In the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(D) In the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls.

Title 42 United States Code S1395 y
(Medicare as Secondary Payor Act)

(b) Medicare as Secondary Payor

(1) Requirements for group health plans

(A) Working Aged under Group health plans

(i) In General

A group health plan -

(I) may not take into account that an individual (or an individual's spouse) who is covered under the Plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title.

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall e entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under the age of 65.

(V) "Group health plan" defined.
In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of title 26, without rgard to section 5000(d) of Title 26. (emphasis added).

. . .

42 U.S.C. 1395 y, subparagraph (b)(1)(E)

(i) Current employment status defined
An individual has "current employment status with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

26 U.S.C. 5000, subparagraph (b)
"Large Group Health Plan" defined

(2) The term "Large group health plans"- means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan). To provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employers of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year...

. . .

(d) Government entities - For purposes of this section, the term "employer" does not include a Federal or other governmental entity.

Subchapter XX--Requirements for certain group health plans for certain state and local employees

Title 42 United States Code §300 bb-1

State and local governmental group health plans must provide continuation coverage to certain individuals.

(a) In general

In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any state that receives fund under this Chapter, by any political subdivision of such a state, or by any agency or instrumentality of such a state or political subdivision, shall provide, in

accordance with this subchapter, that each qualified beneficiary who would lose coverage under the Plan as a result of a qualifying event is entitled, under the Plan, to elect, within the election period, continuation coverage under the Plan.

(b) Exception for certain plans

Subsection (a) of this section shall not apply to --

(I) any group health plan for any calendar year if all employers maintaining such plan normally employ fewer than 20 employees on a typical business day during the preceding calendar year, or

(II) a group health plan maintained for employees by the government of the District of Columbia or any territory or possession of the United States or any agency or instrumentality

Section 300 bb-2. Continuation Coverage

For purposes of §300 bb-1 of this title, the term "continuation coverage" means coverage under the Plan which meets the following requirements:

(1) Type of Benefit Coverage
The coverage must consist of coverage which as of the time the coverage is being provided, is identical to the coverage provided under the Plan to similarly situated beneficiaries under the Plan with respect to whom a qualifying event has not occurred.

If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the Plan pursuant to this part in connection with such group.

(2) Period of Coverage

The coverage must extend at least for the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(A) Maximum Required Period

(i) General Rule for Terminations and Reduced Hours

In the case of a qualifying event described in section 300 bb-3 (II) of this title except as provided in clause (ii) the date which is 18 months after the date of the qualifying event

(ii) Special Rule for Multiple Qualifying Events

If a qualifying event occurs during the 18 months after the date of the qualifying event described in §300 bb-3(II) of this title, the date which is 36 months after the date of the qualifying event described in §300 bb-3(II) of this title.

(iii) General Rule for Other Qualifying Events

In the case of a qualifying event not described in § 300 bb-3(II) of this title, the date which is 36 months after the date of the qualifying event.

In the case of an individual who is determined, under Title II or XVI of the Social Security Act (42 USCA §401 at et seq. or 1381 et seq.) to have been disabled at the time of a qualifying event described in § 300 bb-3(II) of this title, any referencing clause (i) or (ii) to eighteen months with respect to such event is deemed a reference to 29 months, but only if the qualifying beneficiary has provided notice of such determination under §300 bb-6 (III) of this title before the end of such 18 months.

(iv) Qualifying Event Involving Medicare Entitlement
In the case of an event described in §300 bb-3(IV) of this title (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the covered employee for such event or any subsequent qualifying event shall not terminate before the close of the 36 month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act (42 USCA §1395 et seq.)

(B) End of Plan
The date on which the employer ceases to provide any group health

plan to any employee.

(C) Failure to Pay Premium
The date on which coverage ceases under the Plan by reason of a failure to make timely payment of any premium required under the Plan with respect to the qualified beneficiary. The payment of any premium other than any payment referred to in the last sentence of paragraph (2) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies under the Plan.

(D) Group Health Plan Coverage or Medicare Entitlement
The date on which the qualified beneficiary first becomes, after the date of election --

(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary, or

(ii) entitled to benefits under Title XVIII of the Social Security Act (32 USCA §1395 et seq.)

(E) Termination of Extended Coverage for Disability

In the case of a qualified beneficiary who is disabled at the time of a qualifying event described in §300 bb-3(II) of this Title, the month that begins more than 30 days after the date of the final determination under Title XVI of the Social Security Act (32 USCA §401 et seq. or 1381 et seq.) that the qualified beneficiary is no longer disabled.

(3) Premium Requirements

The Plan may require payment of a premium for any period of continuation coverage, except that such premium --

(A) shall not exceed 102% of the applicable premium for such period, and

(B) may at the election of the payor, be made in monthly installments.

In no event may the Plan require the payment of any premium before the day which is 45 days after the day in which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of paragraph (II) (A), any reference in said paragraph (A) of this paragraph (II) "102%" is deemed a reference to "150%" for any month after the 18th month of continuation coverage described in clause (i) or (ii) at paragraph (II)(A).

(4) No Requirement of Insurability

The coverage may not be conditioned

upon, or discriminated on the basis of or lack of, other evidence of insurability.

(5) Conversion Option

In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph II(A) the Plan must during the 180 day period ending on such expiration date provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the Plan.

Section 300 bb-3. Qualifying Event

For purpose of this subchapter, the term "qualifying event" means, with respect to any covered employee, any of the following events which but for the continuation coverage required under the subchapter would result in the loss of coverage of a qualified beneficiary:

(I) The Death of a Covered Employee

(II) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

(III) The divorce or legal separation of the covered employee form the employee's spouse.

(IV) The covered employee becoming entitled to benefits under Title XVIII of the Social

Security Act, 42 USCA §1395 et seq.

Section 300 bb-4. Applicable Premium

For purposes of this subchapter --

(1) In General
The term "applicable premium" means, with respect to any period of continuation coverage of qualified beneficiaries, the cost of the Plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid for by the employer or employee).

(2) Special rule for self-insured clients. To the extent that a Plan is a self-insured Plan --

(A) In General
Except as provided in said paragraph (B), the applicable premium for any period of continuation coverage of a qualified beneficiary shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which --

(i) is determined in an actuarial basis, and

(ii) takes into account such factors as the Secretary may prescribe in the regulations.

(B) Determination of basis of past cost.
If a Plan administrator elects to have this subparagraph apply, the applicable premium for any period

of continuation coverage of qualified beneficiaries shall be equal to --

(i) the cost of the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3) adjusted by

(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in a survey of current business) for the 12 month period ending on the last day of the 6th month of such preceding determination.

(C) Subparagraph (B) not to apply where significant change.

A Plan administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage ended, or in employees covered by, the Plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

(3) Determination Period

The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

Section 300 bb-5. Election

For purposes of this subchapter --

(1) Election Period

The term "election period" means the period which --

(A) begins not later than the date on which coverage terminates under the Plan by reason of a qualifying event,

(B) is of at least 60 days duration, and

(C) ends not later than 60 days after the later of

(i) the date described in said paragraph (A), or

(ii) in the case of any qualified beneficiary who receives notice under §300 bb-6 (4) of this Title, the date of such notice.

(2) Effect of Election on Other Beneficiaries

Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in said paragraph (A)(i) or (B) of section 300 bb-8 (III) of this Title, shall be deemed to include an election of continuation coverage on behalf of any

other qualified beneficiary who would lose coverage under the Plan by reason of the qualifying event. If there is a choice among types of coverage under the Plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

Section 300 bb-6. Notice Requirements

In accordance with regulations prescribed by the Secretary --

(1) The group health plan shall provide, at the time of commencement of coverage under the Plan, written notice to each covered employee and spouse of the employee, if any (other rights provided under this subsection).

(2) The employer of an employee under the Plan must notify the Plan administrator of a qualifying event described in paragraphs (I), (II), and (IV) of §300 bb-3 of this Title within 30 days of the date of the qualifying event.

(3) Each covered employee or qualified beneficiary is responsible for notifying the (administrator) of the occurrence of any qualifying event described in paragraph (III) or (V) of §300 bb-3 of this Title within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under Title II or XVI of the Social Security Act (42 USCA §401 et seq. or 1389 et seq.) to have been disabled at the time of a qualifying event described in §300 bb-3 (II) of this Title is responsible for notifying the Plan administrator of such determination within 60 days after the date

of the determination and shall notify the Plan administrator within 30 days after the date of any final determination under such Title or Titles that the qualified beneficiary is no longer disabled and

(4) The Plan administrator shall notify --

(A) in the case of a qualifying event described in paragraphs (I), (II), or (IV) of §300 bb-3 of this Title any qualified beneficiary with respect to such event, and

(B) in the case of a qualifying event described in paragraph (III) or (V) of §300 bb-3 of this Title where the covered employee notifies the Plan administrator under paragraph (III), any qualified beneficiary with respect to such event, and such beneficiary's rights under this subsection.

For purposes of paragraph "4", any notifications shall be made within 14 days of the date on which the Plan administrator is notified under paragraph (2) or (3), whichever is applicable and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with said spouse at the time such notification is made.

Section 300 bb-7. Enforcement

Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of the subchapter may bring an action for appropriate equitable relief.

Section 300 bb-8. Definitions

For purposes of this subchapter --

(I) Group health plan. The term "group health plan" has the meaning given such term in §162(i)(2) of Title 26.

(II) Covered employee. The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for one or more persons maintaining the Plan (including as an employee defined in §401(c)(I) of Title 26).

(III) Qualified beneficiary.

(A) In general.
The term "qualified beneficiary" means, with respect to a covered employee and their group health plan, any other individual who, and a day before the qualifying event for that employee, is a beneficiary under the Plan --

(i) as the spouse of the covered employee, or

(ii) as the dependent child of the employee

(B) Special rule for terminations and reduced employment
In the case of a qualifying event described in §300 bb-3 (2) of this

Title, the term "qualifying beneficiary" includes the covered employee.

(IV) Plan Administrator
The term "plan administrator" has the meaning given the term "administrator" by §1002 and (16)(A) of Title 29.

New York State

N.Y. Civil Service Law §163: Eligibility for Benefits
Civil Service Law, §163 subpar. 3, N.Y. Civil Service Regulation §73.2(a)(3)

1. All persons in the service of the State, whether elected, appointed or employed, who elect to participate in such health insurance plan shall be eligible to participate therein, provided, however, that the President may adopt such regulations as he may deem appropriate excluding temporary, part-time or intermittent employment.
2. (Omitted)
3. The President shall adopt regulations prescribing the conditions under which an employee or a retired employee may elect to participate in or withdraw from the Plan. Such regulations may also prescribe conditions under which an employee whose service terminates and who is entitled to a vested retirement allowance may continue to participate in the Plan; such conditions shall include the requirement that such person shall pay the full cost of such coverage following termination of his employment

and prior to commencement of the payment of his retirement allowance, unless such person becomes currently entitled to, but defers the receipt of, a retirement allowance or pension from a retirement or pension plan or system administered and operated by the State of New York, or a civil division thereof, including the New York State Teachers Retirement System and the optional retirement programs established under Article 3, Part V and Article 8B of the Education Law.

N.Y. Civil Service Law Section 165: Termination of Active Employment
Civil Service Law, §165, subpar. 1

1. The health insurance coverage of any employee and his dependents, if any, shall cease upon the discontinuance of his term of office or employment, subject to regulations which may be prescribed by the President for extension of coverage and for conversion to an individual contract providing for such other benefits provided under this article as may be provided under such individual contracts under terms approved by the President, the total cost of any such contract to be borne by the employee.

N.Y. Civil Service Regulations 73.2

Rules and Regulations of the New York State Department of Civil Service:
Regulation §73.2 Eligibility

(a) Employees

(1) An employee shall be eligible for coverage under the Plan for himself and for his dependents if any subject to the provisions of this part and of the appropriate contracts applicable to employees and their dependents.

(2) Omitted

(3) Coverage for any employee and his dependents shall cease without notice on the date of termination of his status as an employee as defined in §73.1 of this part. The status of any person as an employee shall be deemed to terminate upon his severance from the payroll, except that for the purposes of continuing his coverage under the Plan, the status of such person as an employee shall be deemed to continue:

(ii) during any period of authorized leave without pay or <u>while a vested employee</u>. (Emphasis added)

EXHIBIT A

METLIFE, INC.
LIST OF SUBSIDIARIES & AFFILIATES
(AS OF SEPTEMBER 30, 2000)[1]

Wholly-Owned Active Subsidiaries

23RD STREET INVESTMENTS, INC. (DE)
334 MADISON EURO INVESTMENTS, INC. (DE)
BENEFIT SERVICES CORPORATION (GA)
CBNJ, INC. (NJ)
COATING TECHNOLOGIES INTRNATIONAL, INC. (DE)
CONVENT STATION EURO INVESTMENTS FOUR COMPANY (UNITD KINGDOM)
COLLABORATIVE STRATEGIES, INC. (MO)
CONNING, INC. (DE)
CONNING & COMPANY (CT)
CONNING ASSET MANAGEMENT (MO)
CONNING CORPORATION (MO)
COVA CORPORATION(MO)
OVA FINANCIAL SERVICES LIFE INSURANCE COMPANY (MO)
COVA FINANCIAL LIFE INSURANE COMPANY (CA)
COVA INVESTMENT ADVISORY CORPORATION (IL)
COVA INVESTMENT ALLOCATION CORPORATION (IL)
COVA LIFE ADMINISTRATION SERVICES COMPANY (IL)
COVA LIFE MANAGEMENT COMPANY (DE)
COVA LIFE SALES COMPANY (DE)
CP&S COMMUNICATIONS, INC. (NY)
CRB CO., INC. (MA)
CRH CO., INC. (MA)
CROSS & BROWN COMPANY (NY)
ECONOMY FIRE & CASUALTY COMPANY (IL)
ECONOMY PREMIER ASSURANCE COMPANY (IL)
EDISON SUPPLY AND DISTRIBUTION, INC. (DE)
EQUITY INTERMEDIARY COMPANY (MO)
EXETR REASSURANCE COMPANY, LTD. (BERMUDA)
FAIRFIELD INSURANCE AGENCY OF TXAS, INC. (TX)
FIRST CONNECT INSURANCE NETWORK, INC. (DE)

---

[1] Gives effect to the sale of Nvest, L.P. and Nvest Companies, L.P. on October 30, 2000.

FIRST COVA LIFE INSURANCE COMPANY (NY)
FULCRUM IFNANCIAL ADVISORS, INC. (MA)
G.A. HOLDING CORPORATION (MA)
GENAM HOLDING COMPANY (DE)
GENAMERICA CAPITAL I (DE)
GENAMERICA CAPITAL I (DE)
GENAMERICA FINANCIAL CORPORATION (MO)
GENAMERICA MANAGEMENT CORPOATION (MO)
GENELCO ASIAPACIFIC LIMITED (HONG KONG)
GENELCO DE MEXICO S.A. DE C.V. (MEXICO)
GENELCO INCORPORATED (MO)
GENERAL AMERICANLIFE INSURANE COMPANY (MO)
GENERAL LIFE INSURANCE COMPANY (TX)
GENERAL LIFE INSURANCE COMPANY OF AMERICA (IL)
GENMARK INCORPORATED (MO)
GENMARK INSURANCE AGENCY OF ALABAMA, INC. (AL)
GENMARK INSURANCE AGENCY OF MASSACHUSETTS, INC. (MA)
GENMARK INSURANCE AGENCY OF OHIO, INC. (OH)
GENMARK INSURANCE AGENCY OF TEXAS, INC. (TX)
HEREFORD INSURANCE AGENCY, INC.(MA)
HEREFORD INSURANCE AGENCY OF ALABAMA, INC. (AL)
HEREFORD INSURANE AGENCY OF IDAHO, INC. (ID)
HEREFORD INSURANCE AGENCY OF MINNESOTA, INC. (MN)
HEREORD INSURANCE AGENCY OF NEW MEXICO, INC. (NM)
HEREFORD INSURANCE AGENCY OF OHIO, INC. (OH)
HEREFORD INSURANCE AGENCY OF OKLAHOMA, INC. (OK)

HEREFORD INSURANCE AGENCY OF WYOMING, INC. (WY)
HYATT LEGAL PLANS, INC. (DE)
HYATT LEGAL PLANS OF FLORIDA, INC. (FL)
INTERACTIVE FINANCIAL SOLUTIONS, INC. (MA)
L/C DEVELOPMENT CORPORATION (CA)
MET LIFE HOLDINGS LUXENBOURG S.A. (LUXEMBOURG)
MET P&C MANAGING GENERAL AGENCY, INC. (TX)
METLIFE AUTO &HOME INSURANCE AGENCY, INC. (RI)
METLIFE CAPITAL CFLI HOLDINGS, LLC (DE)
METLIFE CAPITALCFLI LEASING, LLC (DE)
METLIFE CAPITAL CREDIT L.P. (DE)
METLIFE CAPITAL, LIMITED PARTNERSHIP (DE)
METLIFE CAPTAL TRUST I (DE)
METLIFE CC HOLDING COMPANY (DE)
METLIFE CC HOLDING COMPANY (DE)
METLIFE CENTRAL EUROPEAN SERVICES SPOLKA Z ORGANICZONA ODPOWIEDZIALMOSCIA (POLAND)
METLIFE CREDIT CORP. (DE)
METLIFE EUROOPE I, INC. (DE)
METLIFE EUROPE II., INC. (DE)
METLIFE EUROPE III, INC. (DE)
METLIFE EUROPE IV, INC. (DE)
METLIFE EUROPE V, INC. (DE)
METLIFE FINANCIAL ACCEPTANCE CORPORATION (DE)
METLIFE FUNDING, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF ALABAMA, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF KENTUCKY, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF MASSACHUSETTS, INC. (MA)
METLIFE GENERAL INSURANCE AGENCY OF MISSISSIPPI, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF NORTH CAROLINA, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF TEXAS, INC. (DE)

METLIFE HOLDINGS, INC. (DE)
METLIFE (INDIA PRIVATE LTD. (INDIA)
METLIFE INSURANCE COMPANY OF THE PHILLIPINES, INC. (PHILLIPINES)
METLIFE INTERNATIONAL HODLINGS, INC. (DE)
METLIFE INVESTMENTS ASIA LIMITED (HONG KONG)
METLIFE INVESTMENTS LIMITED (UNITED KINGDOM)
METLIFE INVESTMENTS, S.A. (ARGENTINA)
METLIFE NEW ENGLAND HOLDINGS, INC. (DE)
METLIFE SAENGMYOUNG INSURANCE COMPANY LTD. (SOUTH KOREA)
METLIFE SECURITIES, INC. (DE)
METLIFE SECURITY INSURANCE COMPANY OF LOUISIANA (LA)
METLIFE TEXAS HOLDINGS, INC. (DE)
METLIFE TRUST COMPANY, NATIONAL ASSOCIATION (USA)
METPARK FUNDING, INC. (DE
METRIC ASSIGNOR, INC. (CA)
METRIC CAPITAL CORPORATION (CA)
METRIC MANAGEMENT, INC. (DE)
METRIC PRPERTY MANAGEMENT, INC. (DE)
METRIC REALTY (IL)
METROPOLITAN ASSET MANAGEMENT CORPORATION (DE)
METROPOLITAN CASUALTY INSURANCE COMPANY (RI)
METROPOLITAN DIRECT PROPERTY AND CASUALTY INSURANCE COMPANY (RI)
METROPOLITAN GENERAL INSURANCE COMPANY (RI)
METROPOLITAN GROUP PROPERTY AD CASUALTAY INSURANCE COMPANY (RI)
METROPOLITAN INSURANCE AND ANNUITY COMPANY (DE)
METROPOLITAN LIFE HOLDINGS, NETHERLANDS BV (NETHERLANDS)
METROPLOLITAN LIFE INSURANCE COMPANY (NY)
METROPOLITAN LIFE INSURANCE COMPANY OF HONG KONG LIMITED (HONG KONG)
METROPOLITAN LIFE SEGUROS DE RETIRO S.A. (ARGENTINA)

METROPOLITAN LIFE SEGUROS DE VIDA S.A. (URUGUAY)
METROPOLITAN LIFE UBEZPIECZEN NA ZYIE S.A. (POLAND)
METROPOLITAN LLOYDS, INC. (TX)
METROPOLITAN LIFE SEGUROS E PREVIDENCIA PRIVADA S.A. (BRAZIL)
METROPOLITAN MARINE WAY INVESTMENTS LIMITED (CANADA)
METROPOLITAN PROPERTY AND CASUALTY INSURANCE COMPANY (RI)
METROPOLITAN REALTY MANAGEMENT, INC. (DE)
METROPOLITAN RENSURANCE COMPANY (U.K.) LIMITED (UNITED KINGDOM)
METROPOLITAN TOWER CORP. (DE)
METROPOLITAN TOWER LIFE INSURANCE COMPANY (DE)
METROPOLITAN TOWER REALTY COMPANY, INC. (DE)
MEZZANINE INESTMENT LIMITD PARTNERSHIP-8 (DE)
MEZZANINE INVESTMENT LIMITED PARTNERSHIP-BDR (DE)
MEZZANINE INVESTMENT LIMITD PARTNERSHIP-LG (DE)
MISSOURI REINSURANCE (BARBADOS), INC. (BARBADOS)
NAATHAN & LEWIS ASSOCIATES-ARIZONA, INC. (AZ)
NATHAN & LEWIS ASSOCIATES, INC. (NY)
NATHAN & LEWIS OF NEVADA, INC. (NV)
NATHAN & LEWIS SECURITIES, INC. (NY)
NATHAN AND LEWIS ASSOCIATES OHIO, INCOROPORATED 9OH)
NATHAN AND LEWIS ASSOCIATES OF TEXAS, INC. (TX)
NATHAN AND LEWIS INSURANCE AGENCY OF MASSACNUSETTS, INC. (MA)
NATILOPORTEM HOLDINGS, INC. (DE)
NEW ENGLAND INESTMENT MANAGEMENT, INC. (MA)
NEW ENGLAND LIFE HOLDINGS, INC. (DE)
NEW ENGLAND INVESTMENT MANAGEMENT, INC. (MA)
NEW ENGLAND LIFE HOLDINGS, INC. (DE)
NEW ENGLAND LIFE INSURANCE COMPANY (MA)

NEW ENGLAND PENSION AND ANNUITY COMPANY (DE)
NEW ENGLAND SECURITIES CORPORATION (MA)
NEW ENGLAND PORTFOLIO ADVISORS, INC. (MA)
NEWBURY INSURANCE COMPANY, LIMITED (BERMUDA)
N.L. HOLDING CORP. (DEL)(NY)
NVEST CORPORATION (MA)
OMEGA REINSURANCE CORPORATION (AZ)
ONE MADISON INVESTMENTS (CAYCO) LIMITED (CAYMAN ISLANDS)
ONE MADISON MERCHANDISIGN L.L.C. (CT)
PARAGON LIFE INSURANCE COMPANY (MO)
PARK TWENTY THREE INVESTMENTS COMPANY (UNITED KINGDOM)
SECURITY EQUITY LIFE INSURANCE COMPANY (NY)
SECURITY FIRST FINFANCIAL, INC. (DE)
SECURITY FIRST FINANCIAL AGENCY, INC. (TX)
SECURITY FIRST GROUP, INC. (FL)
SECURITY FIRST GROUP OF OHIO, INC. (OH)
SECURITY FIRST INSURANCE AGENCY, INC. (MA)
SECURITY FIRST INSURANCE AGENCY, INC. (NV)
SECURITY FIRST INVESTMENT MANAGEMENT CORPORATION (DE)
SECURITY FIRST LIFE INSURANCE COMPANY (DE)SEGUROS GENESIS, S.A. (MEXICO)[2]

Companies of which Metlife, Inc. directly or indirectly has actual ownership (for its own account) of 10% through 99% of the total outstanding voting stock.[3]

AMERICAN HORIZON GENERAL AGENCY, INC. (57.2%)(FL)
AMERICAN HORIZON HOLDINGS, INC. (DE)(57.2%)
AMERICAN HORIZON INSURANCE COMPANY (57.2%) (AZ)

---

[2] Ownership of Seguros Genesis, S.A. (Mexico) is as follows: Metropolitan Life Insurance Company owns 85.49%, Metropolitan Tower Corp. owns 7.31% and Metropolitan Asset Management Corporation owns 7.20%.

[3] Does not include real estate joint ventures and partnerships of which MetLife,Inc. and/or its subsidiaries is an investment partner.

AMERICAN HORIZON PROPERTY 7 CASUALTY INSURANCE COMPANY (57.2%)(IL)
AMERICAN HORIZON SERVICES, INC. (57.2%)(DE)
BENEFIT RSOURCE LIFE INSURANCE COMPANY (BERMUDA) LTD. (48.13%)(BERMUDA)
DAN RIVER, INC. (32%)(GA)
EXLIPSE CLAIM SERVICES INC. (25%)(CANADA)
FAIRFIELD MANAGEMENT GROUP, INC. (48.13%)(MO)
GRAND CATHAY SECURITIES INVESTMENT TRUST CO., LTD. (20%)(TAIWAN)
GENERAL AMERICAN ARGENTINA SEGUROS DE VIDA, S.A. (57.9%)(ARGENTINA)
GENESIS SEGUROS GENERALES, SOCIEDAD ANONIMA DE SEGUROS Y REASEGUROS (50%)(SPAIN)
GREAT RIERS REINSURANCE MANAGMENT, INC. (48.13%)(MO)
MALAYSIA LIFE REINSURANCE GROUP BERHAD (17.3%)(MALAYSIA)
MERCADIAN CAPITAL L.P. (95%)(DE)
MERCADIAN FUNDING L.P. (95%)(DE)
METRIC COLORADO, INC. (80%)(CO)
METROPOLITAN LLOYDS INSURANCE COMPANY OF TEXAS[4](TX)
METROPLITAN STRUCTURES (50%)(IL)
P.T. METLIFE SEJAHTERA (62%)(INDONESIA)
REGAL ATLANTIC COMPANY (BERMUA) LTD. (57.9%(BERMUDA)
REINSURANCE COMPANY OF MISSOURI, INCORPORATED (57.9%)(MO)
REINSURANCE GROUP OF AMERICA, INCORPORATED (57.9%)(MO)
REINSURANCE PARTNERS, INC. (57.9%)(MO)
RGA AMERICAS REINSURANCE COMPANY, LTD. (57.9%)(BARBADOS)
RGA ARGENTINA, S.A. (57.9%)(ARGENTINA)
RGA AUSTRALIAN HOLDINGS PTY LIMITED (57.9%)(AUSTRALIA)
RGA CANADA MANAGEMENT COMPANY, LTD. (57.9%)(CANADA)

---

[4] Affiliate

RGA CAPITAL LIMITED (57.9%)(UNITED KINGDOM)
RGA FINANCIAL GROUP, L.L.C. (35.04%)(DE)
RGA FINANCIAL PRODUCTS LIMITED (57.9%)(CANADA)
RGA HOLDINGS LIMITED (57.9%)(UNITED KINGDOM)
RGA INTERNATIONAL LTD. (57.9%)(CANADA)
RGA LIFE REINSURANCE COMPANY OF CANADA (57.9%)(CANADA)
RGA MANAGING AGENCY LIMITED (57.9%(UNITED KINGDOM)
RGA REINSURANCE COMPANY (57.9%)(MO)
RGA REINSURANCE COMPANY (BARBADOS) LTD. (57.9%)(BARBADOS)
RGA REINSURANCE COMPANY OF AUSTRALIA LIMITED (57.9%)(AUSTRALIA)
RGA REINSURANCE COMPANY OF SOUTH AGRICA LIMITD (57.9%)(SOUTH AFRICA)
RGA REINSRUANCE (UK) LIMITED (57.9%)(UNITED KINGDOM)
RGA SOUTH AFRICAN HOLDINGS (PTY) LTD. (57.9%)(SOUTH AFRICA)
RGA (U.K.) UNDERWRITING AGENCY LIMITED (57.9%)(UNITED KINGDOM)
SANTANDER MET, S.A. (50%(SPAIN)
SEGUROS GENESIS, S.A. (SPAIN)(50%)(SPAIN)
ST. JAMES FLEET INVESTMENTS TWO LIMITED (34%)(CAYMAN ISLANDS)
STATE STREET RESEARCH STRATEGIC PORTFOLIOS: AGGRESSIVE[5] (63.9%)(MA)
STATE STREET RESEARCH STRATEGIC PORTFOLIOS: SMALL CAP VALUE[6] (99.2%)(ma)
TEXAS AMERICAN HORIZON SERVICES AGENCY, INC. (57.2%)(TX)
TRIAD RE, LTD. (32.36%)(BARBADOS)

---

[5] Mutual Fund

[6] Mutual Fund

EXHIBIT B

CERTIFICATE OF INTERESTED PARTIES
FOR
UNITED HEALTHCARE CORPORATION

UHC Management Company, Inc.
United Health and Life Insurance Company
United Behavioral Systems, Inc.
UHC TPA, Inc.
Physicians of Georgia, Inc.
United HealthCare of Georgia, Inc.
United HealthCare of Utah
Midwest Physicians Health Programs, Inc.
Physicians Health Plan of Greater St. Louis, Inc.
Physicians Health Plan of the Midwest, Inc.
PrimeCare Health Plan, Inc.
United HealthCare of Ohio, Inc.
All Care, Inc.
All Care Acquisition Co., Inc.
Western Ohio Headquarters
United Health and Life Insurance Company of Ohio
United Health Plans of New England, Inc.
Share Health Plan of Illinois, Inc.
United HealthCare of the Midlands, Inc., f/k/a Share Health Plan of Nebraska, Inc.
United HealthCare of the Midlands Network, Inc. f/k/a Share Health Care, Inc.
Chicago HMO, Ltd.
United Health and Life Insurance Company of Illinois f/k/a Chicago Health Multi Option Insurance, Ltd.
FOCUS Healthcare Management, Inc.
Complete health Services, Inc.
Complete Health, Inc.
Alabama Health Network, Inc.
Complete Health of Alabama, Inc.
Complete Health of Arkansas, Inc.
Complete Health of Georgia, Inc.
Complete Health of Mississippi, Inc.
Complete Health of Tennessee, Inc.
Dental Benefits Management, Inc.

CompManagement, Inc.
Rx Management, Inc.
Complete Health Partners, Inc.
Community Health Network of Louisiana, Inc.
Louisiana Health Partners, Inc.
Complete Health of Louisiana, Inc.
Lousiana Health Management Company
Ramsay-HMO Inc.
Ultima RX, Inc.
Ramsay Life and Health Insurance Company
Employers Insurance Services Group, Inc.
CAC Management, Inc.
CAC-Properties, Inc.
CAC - United HealthCare Plans of Florida, Inc. f/k/a CAC-Ramsay Health Plans, Inc.
United HealthCare Plans of Florida, Ind. f/k/a C.A.C. Health Plan, Inc.
United Medical Group, Inc.
Ramsay Health Plans (Puerto Rico), Inc.
GenCare Health Systems, Inc.
GenCare Management Company
GenCare Preferred Provider Organization, Inc.
GenCare Dental Plan, Inc.
Group Sales and Service of Puerto Rico, Inc.
The MetraHealth Insurance Company (Ins)
MetraHealth Management Corporation
MetraHealth Care Plan of Arizona, Inc.
MetraHealth Care Plan of California, Inc.
MetraHealth Care Plan of Colorado, Inc.
MetraHealth Care Plan of Florida, Inc.
MetraHealth Care Plan of Illinois, Inc.
MetraHealth Care Plan of Kansas City, Inc.
MetraHealth Care Plan of Kentucky, Inc.
MetraHealth Care Plan of Massachusetts, Inc.
MetraHealth Care Plan of New Jersey, Inc.
MetraHealth Care Plan of New York, Inc.
MetraHealth Care Plan of Ohio, Inc.
MetraHealth Care Plan of Pennsylvania, Inc.
MetraHealth Care Plan of St. Louis, Inc.
MetraHealth Care Plan, Inc.
MetraHealth Care Pan of Virginia, Inc.

MetraHealth Care Plan of Wisconsin, Inc.
MetraHealth Insurance Company of New York
The MetraHealth Employee Benefits Company, Inc.
MetraRealty, Inc.
The MetraHealth Care Holding Company
The MetraHealth Care Network, Inc.
MetraHealth Care Plan of Greater Chicago, Inc.
MetraHealth Care Plan of Louisiana, Inc.
MetraHealth Care Plan of Upstate New York, Inc.
MetraHealth Care Plan of Texas, Inc.
ProAmerica Managed Care, Inc.
The MetraHealth Telebrokerage, Inc.
United HealthCare Administrators, Inc.
MetraComp, Inc.
MetraHealth Pharmacy Management, Inc.
The Center for Corporate Health, Inc.
U.S. Behavioral Health
U.S. Behavioral Health Plan, California
Behavioral Health Administrators
MetraHealth Service Corporation
HealthSpring Inc.
HealthSpring of Pennsylvania, Inc.
HealthSpring of Georgia, Inc.
HealthSpring of Ohio, Inc.
Healthspring of Illinois, Inc.
MetLife Group Administrator, Inc.
Corporate Health Strategies, Inc.